An exploratory study of the peer support worker role within a multi-disciplinary mental health team: Multiple perspectives in an Irish context

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Abstract

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Introduction: Peer Support Workers (PSWrs) are employed in mental health services with the purpose of supporting service users by utilizing their own personal experience of mental health difficulties. The introduction of a new role into an existing team or to complement an existing care pathway constitutes a complex intervention, for which systematic feasibility and piloting work in both development and evaluation are a necessity. **Objectives:** The aim of the study was to explore and compare the views and experiences of PSWrs, Supervisors, and Mental Health Professionals (MHPs) in relation to the employment of PSWrs in 4 mental health services in Ireland. **Methodology:** The overall research design aimed to collect information and draw conclusions for the future employment of PSWrs within statutory mental health services. Each participant group took part in a semi-structured interview (PSWrs: 4; Supervisors: 2; MHPs: 6) yielding a total of 12 interviews. Thematic analysis was conducted and the data compared across the three participant types. **Results:** Across nine topics, a total of 53 themes emerged from qualitative data. **Discussion:** Diverging views across participant groups, methodological strengths and weaknesses and significant implications for future directions for research, implementation and policy were discussed. **Conclusions:** The results of this study suggest the importance of developing clear guidelines for the effective implementation of peer support working before the role is widely rolled out in mental health settings and further research into their effectiveness be considered.

Declaration

I declare that this thesis is entirely my own work, other than the counsel of my supervisors. Sources used have been cited and acknowledged within the text. This dissertation is submitted in partial fulfilment of the requirements for the Doctorate in Clinical Psychology (Ph.D.) at the University of Limerick. It has not been submitted previously to University of Limerick or any other academic institution.

Date: _____ Signature: _____

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The completion of this thesis has had its moments and it's been quite an experience. I could not have completed it without the support of those around me. I would like to give a huge thank you to my parents Paddy and Margaret and my brother Cathal for their constant support, throughout the lifespan of this project. Finally I would like to give a special thank you to my fiancé Gerald for his love, patience and understanding throughout the long hours spent on this research. Hopefully I can return the favour to you all someday in the future!

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Chapter 1: Thesis Overview

1.1 Introduction

The aim of this thesis is to explore and compare the views and experiences of Peer Support Workers (PSWrs), Supervisors, and Mental Health Professionals (MHPs) in relation to the employment of PSWrs on mental health teams.

1.2 Thesis Structure

1.2.1 Chapter 2: Literature Review

The search engines used in this literature review include PsychINFO, PsycARTICLES, MEDLINE and Social Sciences Full Text. A search of articles was conducted for the following terms in papers: "peer support" and "mental health". Articles were limited to a date range of 2007-2018, the area of adult mental health and full free peer-reviewed English texts. This yielded 933 articles. Following this, articles were screened at a title, abstract and full paper level, to determine if they were of relevance to this study. The reference sections of studies were reviewed to see if other relevant studies were cited in this paper. Following this a search was conducted in GoogleScholar to ensure important articles were not lost. The chapter will begin by briefly discussing the origins of recovery, definitions and components of recovery, and finally critique the concept. The origins, definitions, models, principles, role and activities of the PSWr role will then be discussed. The issue of 'peerness' and the uniqueness of the role will be explored. Research on the integration of PSWrs into mental health teams will also be explored and evaluated. Following on from this, research relating to impact of PSWrs working with service users (SUs), team members and PSWrs themselves will then be assessed. This chapter will then explore the research which examines the training of PSWrs. Finally, this chapter concludes with a brief introduction and outline of the primary aims of the current study.

1.2.2 Chapter 3: Methodology

The rationale underpinning research design and methodological framework selection will be discussed in this chapter. Approaches to participant recruitment, descriptions of participant characteristics, illustration of procedural steps, and modes of data collection and analysis will also be outlined. Additionally, ethical issues and concerns around reliability and validity will be addressed in this section.

1.2.3 Chapter 4: Results

This results chapter will present synthesised findings from the twelve transcribed participant interviews through a combination of illustrative quotes and commentary.

1.2.4 Chapter 5: Discussion

Having outlined the findings in Chapter 4, Chapter 5 will provide a rationalization of these findings in the context of the literature discussed in Chapter 2. The study's strengths and limitations and a critical reflection of the researcher's involvement in the research will be presented prior to a discussion of the implications in relation to clinical practice, policy, and future research. This chapter concludes with a summary of the study and reflections on the overall research process.

1.3 Positionality of the Researcher

In terms of global mental health, there is an urgent need to address some of the major barriers to accessing mental healthcare. It has been suggested there is a need for the development of creative and effective strategies to address these issues. If successful, such an innovation could improve the lives of millions affected by mental illness (Rebello, Marques, Gureje, & Pike, 2014).

A review by Rebello et al. (2014) reported on recent evidence of the feasibility of implementation and efficacy of training of 'Non- Specialists' also known as Peer Support Workers (PSWrs). While this review emphasised that such interventions showed promise for building clinical capacity and also demonstrated an expansion in mental health coverage, it also noted that further research was necessary to ensure implementation is beneficial to mental health services (Rebello et al., 2014).

From clinical experience both prior to my current doctoral studies and on the various placements of the PhD programme, the problem of long waiting lists is a significant on-going issue. It is clear that demand for services perennially exceeds supply. Furthermore, for those SUs who receive care, many report they do not feel properly heard or understood. This situation led me to question whether PSWr involvement in mental health teams could have a long-term positive impact on these two barriers. However, before such an intervention could be rolled out and evaluated, I deemed it

important to address basic issues of their involvement and so I aimed to elicit and compare the perspectives of three different groups, PSWrs, Supervisors, and MHPs. Multiple perspectives would provide an overall view and potentially highlight formerly unidentified gaps allowing for better decision- making in relation to PSWr involvement going forward.

Chapter 2: Literature Review

Definition, history, origins and policies of peer support and personal recovery model

2.1 Introduction

This section will firstly discuss the definition of Peer Support Worker (PSWr). It will continue with a description of the history and origins of mental health policy around the world for personal recovery and peer support.

2.2 The definition of the Peer Support Worker (PSWr)

The PSWr has been vaguely defined within the literature as individuals with a history of living successfully with serious mental illness who, in turn, support others with serious mental illness (Chinman et al., 2014; Davidson et al., 2006; Davidson et al., 2012; Rebeiro Gruhl, LaCarte, & Calixte, 2016; Salzer et al., 2010; Vandewalle et al., 2017; Wrobleski et al., 2015). The concept of 'Peer Support Worker' grew out of the Mental Health Recovery Framework (Repper & Carter, 2011).

2.3 Origins of Personal Recovery

2.3.1 Traditional Definition: Clinical Recovery

The traditional clinical definition of 'recovery' is derived from the medical model and is thus understood to be the return of the patient's former state of health. This form of recovery is known as 'clinical recovery' and is normally reached through hospitalization and medication (Petersen, Friis, Haxholm, Nielsen, & Wind, 2015). Clinical recovery centers on the absence of disease or full symptom remission and is based on clinical outcomes which are professionally rated. It also includes having full- or part-time work/education, independent living without supervision by informal caregivers, and friends to partake in social activities with. These conditions must be met for a period of two years for 'recovery' to be considered achieved (Libermann & Kopelowicz, 2002; Macpherson et al., 2016; Slade, Lindsay, & Jarden, 2017).

Whilst psychopharmacological treatments have improved and are considered fundamental to mental illness management, they arguably play little part in restoring the skills needed for leading a satisfying and fulfilling life (Frost et al., 2017). It is also

evident that medications have been unable to solve the issue of relapse (Wykes & Drake, 2012) and also carry significant side effects and risks, including over-reliance, poly-pharmacy, and inappropriate use (Frost et al., 2017; Kuipers, Yesufu-Udechuku, Taylor, & Kendall, 2014). This particular definition of recovery does not vary across individuals and may therefore be easily measured and investigated in empirical studies (Slade & Wallace, 2017).

2.3.2 New Definition: Personal Recovery

Over the past two decades the traditional definition of recovery has been re-conceptualised (Slade et al., 2017). Known as 'personal recovery' this reformulation is not concerned with a return to the pre-illness state prescribed in the medical model, but rather focuses on building a meaningful and satisfying life that is directed by the client regardless of whether or not there are ongoing or recurring symptoms (Field & Reed, 2016; Lukens & Solomon, 2013; Mental Health Commission, 2005; Shepard, Boardman, & Slade, 2008). Commentators concur that such elements of personal recovery are unique to an individual and therefore hard to pin down with precision (Macpherson et al., 2016; Ramon, Healy, & Renouf, 2007; Shepard et al., 2008; Slade, 2017; Slade et al., 2017). While several attempts have been made to measure personal recovery, (Andresen, Caputi, & Oades, 2006; Campbell-Orde, Chamberlin, Carpenter, & Leff, 2005; Tondora et al., 2006) the individualization of the process has hampered the empirical observation and measurement of its development (Ramon et al., 2007). For this reason, the concept of personal recovery has no operational or scientific definition to date. This research aims to explore the definition of personal recovery across three groups, peer support workers (PSWrs), supervisors, and mental health professionals (MHPs), in order to determine diverging or overlapping views.

2.3.3 Personal Recovery and Mental Health Policy around the World

The recent definition of recovery developed from the 1960's and '70's Civil Rights activism in the United States (Macpherson et al., 2016; Shepard et al., 2008) and the consumer, user and survivor mental health movements of the 1980s and 1990s (Macpherson et al., 2016; Ramon et al., 2007; Roberts & Wolfson, 2004; Shepard et al., 2008) The force and popularity of these humans rights' movements has given rise to a sustained interest in incorporating a recovery 'orientation' into the organisation and delivery of mental health services around the world (Burgess, Pirkis, Coombs, & Rosen 2011; Leamy et al., 2016; Macpherson et al., 2016; Naughton, Collins, & Ryan, 2015)

which has been described as the first genuinely post-institutional service philosophy (Mental Health Advocacy Coalition, 2008; MHCC, 2015).

The formalization of 'recovery' as a national policy was first instituted in New Zealand, the United States, Australia, Scotland and England (Naughton et al., 2015). In Ireland, recovery is one of the quality markers identified by users of mental health services and is now intrinsic to the national mental health policy (Mental Health Commission, 2005; Shah, Nolan, Ryan, Williams, & Fannon, 2016). The policy document, "A Vision for Change", (2006) was the first Irish policy to outline the need to adopt and promote a recovery-based approach to mental health services and emphasised the need for a recovery approach in the design, development, and delivery of mental health services (Department of Health and Children, 2006). This recovery-focused approach is also identified as a key standard of care in the 'Quality Framework for Mental Health Services in Ireland' (Mental Health Commission, 2007). Further such documents have been published by the Mental Health Commission (2005a; 2005b) and Mental Health Reform (McDaid, 2013) which make it clear that Irish statutory services could be more "recovery orientated".

2.3.4 Critique of Recovery

Although the recovery concept is very popular and is part of policy and practice around the world, it is not without its critics. For instance, it has been highlighted that the current conceptualisation of personal recovery evolved from the findings of follow-up studies using the original medical model of recovery (Ramon et al., 2007). Furthermore, research has questioned how a concept which draws much of its strength from qualitative approaches can survive and influence policy and practice (Australian Health Ministers, 2003; Mancini, Hardiman, & Lawson, 2005; Ramon et al., 2007) in an era which increasingly privileges 'evidence-based practice' which emphasizes the use of the 'gold standard' randomized controlled trial. It has been suggested that converting policy rhetoric on recovery into clinical practice has proved challenging, partly because the policy is not yet matched by a strong evidential base (Slade et al., 2014).

2.4 History of 'Peer Support' in Mental Health

Peer support in the context of mental health can be traced back to the 1920s when young people recovering from schizophrenia were recruited to be assistants at an inpatient clinic in Baltimore, USA for others affected by schizophrenia (Perry, 1982). In the wake of this, more peers were gradually recruited to support or mentor those facing similar struggles to their own (Edelson, 1964; Jones, 1953; Tse, Tsoi, Wong, Kan, & Kwok, 2014).

By the mid-1970s the peer support model had grown still further with peer support services assuming the form of self-help groups, consumer- or peer-operated services, and other auxiliary organisations for people with lived experiences of mental health and substance use difficulties (Davidson, Chinman, Sells, & Rowe, 2006; Grant, Reinhart, Wituk, & Meissen, 2012; Myrick & Del Vecchio, 2016*).*

PSWrs are now frequently used to support recovery (Pitt et al., 2013). The settings in which PSWrs provide support today range from correction facilities and prisons to substance-use treatment services, recovery community and consumer-run programs, hospitals and patient-centered medical homes, community health centres, emergency departments, and mental health outpatient and inpatient facilities (Cronise et al., 2016; Salzer et al., 2013; Unger, Pfaltzgraf & Nikkel, 2010; Migdole et al., 2011; Myrick & Del Vecchio, 2016).

2.4.1 Peer Support and Mental Health Policy around the World

Driven by recovery orientation within national mental health policies, Canada, Australia, New Zealand, South America, Africa, Asia, Scotland, Wales, England and a number American states, are currently at various stages of conceptualizing and implementing peer support services in both voluntary and statutory mental healthcare (Shepard et al., 2008; Davidson, Bellamy, Guy, & Miller, 2012; Mahlke et al., 2014; Slade et al., 2014; Oades, Slade, & Jarden, 2017; Gillard & Holley, 2014; Repper et al., 2013; Simpson et al., 2014).

The UK Implementing Recovery through Organisational Change (ImROC) programme maintains that the introduction of PSWrs is a powerful way of driving a more recovery-focused approach within organisations (Trachtenberg et al., 2013). Peer support services now generally occur in three different service settings:

1. naturally occurring mutual support groups
2. consumer-run services
3. clinical and rehabilitative settings which employ peers as providers

(Cronise et al., 2016; Naughton et al., 2015; Salzer, Schwenk, & Brusilovskiy, 2010*).*

In the United States, peer-operated services have been recognized as best practice (U.S. Department of Health & Human Services, 2011; Wrobleski, Jarus-Hakak, & Suto, 2015), while in Ireland the "A Vision for Change" (2006) policy document recommended that the use of PSWrs should be established within the mental health system as a means to support SUs (Expert Group on Mental Health Policy, 2006).

2.5 Conclusion

The PSWr role grew out of the Mental Health Recovery Framework but has only been vaguely defined within the literature. Over the past decade, peer support services have grown to become an integral component of the mental health care system workforce around the world, both within statutory health services and the charitable/voluntary sector (Faulkner & Bassett, 2012; Gillard, Edwards, Gibson, Owen, & Wright, 2013; Simpson, Quigley, Henry, & Hall, 2014; Kaplan, 2008; Sheedy & Whitter, 2009; Myrick & Del Vecchio, 2016).

Personal Recovery

2.6 Introduction

This section will discuss the components, processes, stages, characteristics and framework of personal recovery. It will then explore the literature in relation to knowledge of recovery concept among providers.

2.7 Components of Personal Recovery

Research has ring-fenced the many conditions and components of recovery. Studies into personal recovery stress the importance of understanding an individual's narrative as a non-linear journey of growth consisting of attainable goals and personal and social development (Davidson, O'Connell, Tondora, & Evans, 2006; Jacobson & Greenley, 2001; Mental Health Commission, 2005). Other research based on consumer accounts of recovery found it to include both internal and external conditions (Jacobson & Greenley, 2001) as illustrated below:

Table 1: Conditions in the process of recovery (adapted from: Jacobson & Greenley, 2001)

Process of Recovery	
Internal Conditions:	**External Conditions:**
• Hope • Healing • Empowerment • Connection	Human rights • A positive culture • A recovery-oriented service

Other critical factors observed within the process of personal recovery include dealing with stigma (Deegan, 1988) and the development of self-confidence and hope (Corrigan, Watson, & Barr, 2006). Research by Andresen et al. (2003; 2006) suggests that there are four key components to psychological recovery that take place through a five stage process as illustrated in Table 2:

Table 2: The components and stages of recovery (adapted from: Andresen et al., 2003; 2006)

Four Components of Recovery	
Finding and maintaining hope: believing in oneself; having a sense of personal agency; optimism about the future	***1. Re-establishment of a positive identity:*** finding a new identity which incorporates illness, but retains a core, positive sense of self
2. Building a meaningful life: making sense of illness; finding a meaning in life despite illness; engaged in life	***3. Taking responsibility and control:*** feeling in control of illness and in control of life

Five Stages of Recovery	
1. Withdrawal:	characterized by a profound sense of loss and hopelessness
2. Awareness:	realization that all is not lost and that a fulfilling life remains possible
3. Preparation:	taking stock of strengths and weaknesses regarding recovery and starting to work on developing recovery skills
4. Rebuilding:	actively working towards a positive identity, setting meaningful goals and taking control of one's life

Leamy and colleagues conducted a systematic review of articles exploring personal recovery and completed a narrative synthesis of findings to develop a conceptual framework (Leamy, Bird, Le Boutillier, Williams, & Slade, 2011). Based on 97 peer-reviewed papers, they identified thirteen distinct characteristics of recovery and created the CHIME framework which includes five recovery processes as illustrated in Table 3:

Table 3: The characteristics and framework of recovery (adapted from: Leamy et al., 2011).

13 Characteristics of recovery				
An active process	A struggle	A gradual process	A journey	Involving stages/phases
An individual, unique process	A multi-dimensional process	A non-linear process	A life-changing experience	A trial and error process
Helped by a supportive healing environment	Possible without professional support	Occurring in the absence of curing mental illness		
CHIME Framework				
Connectedness	Hope about the future	Identity	Meaning in Life	Empowerment

2.8 Personal recovery knowledge among providers

The meaning of recovery has been examined from the SU (Piat, Sabetti, & Couture, 2009) and provider (Piat & Lal, 2012) perspectives; however no studies from the literature review were found to examine and compare the meaning of recovery from the PSWr, supervisor and MHP perspectives.

To date, various scales pertaining to recovery orientation have been developed, including individual's attitude toward recovery for use with mental health service providers or people with mental illness (Borkin, Stefen, Ensfeld et al. 2000; Resnick, Fontana, Lehman & Rosenheck, 2005; Salyers, Brennan and Kean, 2013) competence to promote recovery (Russinova, Rogers, Cook, Ellison & Lyass, 2013; Blau, Surges Tatum, Goldberg et al., 2014) and the recovery orientation of services (Williams, Leamy and Bird, 2012). Among such scales, the Recovery Knowledge Inventory (RKI), developed in the USA, is one of the influential and predominantly used scales to assess knowledge and attitude towards recovery-oriented practices among mental health service providers (Bedregal, O'Connell and Davidson, 2006; Chiba, Umeda, Goto et al., 2017). Benefits of educational programmes for increasing providers recovery orientation have also been cited (Chen, Krupa, Lysaght, McCay, & Piat, 2014; Park, Zafran, Stewart, et al., 2014; Peebles, Mabe, Fenley et al. (2009); Salgado, Deane, Crowe & Oades, 2010).

2.8.1 Personal Recovery Knowledge among Irish providers

A study which investigated Irish mental health practitioner's knowledge of and attitudes toward recovery using a descriptive survey approach highlighted the need for improvements in their overall understanding of the area (Cleary & Dowling, 2009). This led to the Advancing Recovery in Ireland Project (ARI) which promoted recovery-orientated services and emphasized the need to 'benchmark' progress. However, a recent study undertaken by Gaffey, Evans, and Walsh (2016) which used the same methodology found no significant score differences in terms of knowledge or attitudes compared to the earlier study (Cleary & Dowling, 2009), despite significantly more respondents having received training specific to recovery (40% versus 23%). Results suggested that working in dual settings, and being a non-nurse was associated with better recovery knowledge scores. Training was found to be the strongest factor predicting better recovery knowledge. Level of experience did not impact on recovery

knowledge scores. It must be noted that due to the methodology used, research results may reflect a certain level of bias due to the absence of statistical tests. Moreover, it does not identify a rationale for the lack of change in recovery knowledge. However, key recommendations from the study did identify the need for more extensive recovery training, the use of 'recovery champions', the introduction of peer support workers (PSWrs), and development of local policies and protocols to support recovery work (Gaffey et al., 2016).

2.9 Conclusion

Personal recovery is evidently a multifaceted concept with many different components and conditions. Research suggests that adding PSWrs to mental health teams can support recovery knowledge. To the author's awareness, no studies have attempted to explore multiple perspectives in relation to the definition of recovery and the most important aspects of recovery. This study aims to explore these areas across three groups, PSWrs, supervisors, and MHPs, in order to determine whether knowledge differs between groups or whether certain overlaps exist.

The Peer Support Worker (PSWr) and the issue of 'peerness'

2.10 Introduction

This section will discuss the fundamental issue of 'peerness', the most important equivalent experiences and limitations of 'peerness'.

2.11 The issue of 'peerness' for PSWrs

There is a fundamental issue for the peer support role which has not been addressed in the literature and could be considered a significant lacuna. At the core of the PSWr 'approach' is the assumption that people of similar experiences can better relate and can consequently offer more authentic empathy, support and validation (Mead, et al., 2001; Mead & McNeil, 2004; 2006). This suggests that there is an "essential peerness" at the foundation of peer support work (Silver & Nemec, 2016) which presents challenges to the demands of logical exactitude. The development of a definition which properly classifies the constitution of "peerness" in the context of a mental health setting would arguably educe a more consistent method of measuring and evaluating the phenomenon. This study therefore aims to explore the definition of "peerness" from the perspectives of PSWrs, supervisors, and MHPs.

Muralidharan, Lucksted, Peeples & Goldberg (2017), noted that the issue of 'peerness' for PSWrs outside of mental health in health/wellness interventions. One study found peer coaches' experiences with smoking cessation were very salient to participants, perhaps more so than their identity as mental health consumers (Dickerson et al., 2016). Another study found lived experiences as veterans and mental health consumers appeared much more important than their experiences with specific health behaviours which were the focus of the health intervention. They suggested that the aspects of "peerness" that are most essential for peer-delivered health/wellness interventions requires further investigation (Chinman et al., 2017). A study by Clark, Barrett, Frei and Christy (2016) found veterans identified "having served in the US armed forces" as the primary characteristic that made a peer a peer. All participants also had a trauma-related disorder, and experience with trauma issues had the second highest rating. The strong association between having served in combat and valuing that in a peer support person supports. Research investigating peer support for parents who have mental health

difficulties found in a qualitative study that a supportive relationship between a parent PSWr and a parent with mental health difficulties may depend on the perceived similarity of characteristics other than the shared lived experiences of parenting, family life, and mental illness (Nicholson & Valentine, 2018).

There is a conspicuous lack of research on both the limitations and the most important equivalent experiences between a PSWr and a SU. It has been noted that SU involvement in a mental health service is not a homogeneous experience (Tse, Tang, & Kan, 2015) and as such ringfencing the terms of peership is problematised by the variance of human experience. In short, it does not necessarily follow that all peers have experience's which are comparable to SUs in relation to type of mental health difficulty, illness of particular severity, or knowing the ropes of the local mental health service. Social factors such as poverty, trauma, homelessness, or being between multiple foster homes also merit consideration, along with the personal characteristics of gender, race and ethnicity (Silver & Nemec, 2016). There is a lack of research to ascertain whether certain equivalent experiences are particularly important in establishing a peer relationship within mental health settings (Clark, Barrett, Frei, & Christy, 2016). Research conducted with PSWrs and MHPs suggests that the therapeutic relationship is the most important factor for recovery, regardless of the type of intervention received (Wrobleski et al., 2015). This research was limited by the small sample size which can lead to unreliable effect estimates. However, the results were consistent with research on translating attachment theory into clinical practice (Prenn, 2011).

2.12 Conclusion

There is a conspicuous lack of research investigating what "peerness" is, the limitations and the most important equivalent experiences of being a peer. The study aims to address this gap and also aims to compare the views of PSWr, supervisor, and MHP on these topics.

The PSWr role

2.13 Introduction

This section will firstly discuss the definition and titles of the PSWr. It will then explore the literature outlining the models, roles, duties and activities of the PSWr. Finally this section will demark the contributions of the PSWr role and their differences and similarities to MHPs.

2.14 The definition of the Peer Support Worker

As previously stated, the PSWr has been vaguely defined within the literature as individuals with a history of living successfully with serious mental illness who, in turn, support others with serious mental illness (Chinman et al., 2014; Davidson et al., 2006; Davidson et al., 2012; Rebeiro Gruhl, LaCarte, & Calixte, 2016; Salzer et al., 2010; Vandewalle et al., 2017; Wrobleski et al., 2015). The imprecision of this definition is compounded by the confusing assortment of PSWr nomenclature and titles used within the relevant literature which include, peer support specialist, peer mentor or counsellor, recovery support specialist, recovery coach, client liaison, peer-bridger, family support navigators, and numerous others (Myrick & Del Vecchio, 2016). A survey of certified PSWrs found 291 respondents reported no less than 105 different job titles (Salzer et al., 2010), the most common being "certified PSWr," "peer support specialist," and "certified peer support specialist.

2.14.1 Models and Mechanisms of Peer Support

A number of peer support programs are based upon the psychosocial rehabilitation model (Psychosocial Rehabilitation/Re´adaptation Psychosociale Canada [PSR/RPS Canada], 2010). This model focuses on supporting individuals undergoing recovery from losses through role reclamation, and goal attainment. It involves working with people in a culturally sensitive way and attending to specific environmental and social aspects (PSR/RPS Canada, 2010). This model parallels the values and beliefs of the Canadian Model of Occupational Performance and Engagement (CMOP-E; Polatajko, Townsend, & Craik, 2007). Both models are particularly mindful of culture, environment, and the activities of daily life (Wrobleski et al., 2015). It must be

cautioned however that imposing a peer support "model", however carefully developed, risks sending a message that peer support is something to be learnt, rather than being grounded in the experiential knowledge of peers (Gillard et al., 2017).

It is important to note that certain PSWr programmes are not theory-driven and as such do not adhere to prescribed mechanisms of action or clearly delineated outcomes (Delman & Delman, 2017). Despite the continuing growth and expansion of PSWrs, a lack of understanding of what the PSWr role entails still prevails and occasions considerable international diversity in both implementation and research (Davidson, 2015; Mahlke et al., 2014; Myrick & Del Vecchio, 2016; Rogers et al., 2016).

2.14.2 Role, duties and activities of the PSWr

The role has been argued to be a method of bridging the gap between the mental health system and the SU (Chinman et al., 2010). It is also regarded as a means of promoting a wellness model which focuses on individual SU strengths (Carter, 2000), a "role-model" role which aims to restore SU hope through positive self-disclosure (Fuhr et al., 2014; Rebeiro Gruhl et al., 2016), and a "recovery champion" who supports 'recovery working' within teams and services (Gaffey et al., 2016). The literature has also proposed that the PSWr role includes sharing experiences, empowerment, and offering respect, help, acceptance, empathy, support, validation, companionship, information about how to cope with mental illness, and hope for another person pursuing recovery (Gordon & Bradstreet, 2015; Simpson, Flood, Rowe, Quigley, & Henry et al., 2014).

The list of duties undertaken by PSWrs is similarly broad and may depend on many factors, such as whether the PSWrs is a paid or volunteer provider (Myrick & Del Vecchio, 2016), and also the setting, service model, credentials, and field in which PSWrs work (Gordon & Bradstreet, 2015). The activities can include but are not limited to the following: one-to-one work, running recovery education and mutual support groups, supporting SUs to use self-management tools (Allen, Radke, & Parks, 2010; Gordon & Bradstreet, 2015); emotional support, support based on appraisal, support and befriending, case management, disease self-management, counselling, outreach, coaching advocacy (Fuhr et al., 2014); wellness coaching services (Swarbrick, Murphy, Zechner, Spagnolo, & Gill, 2011; Myrick & Del Vecchio, 2016); and guiding SUs

through fragmented systems to interventions (Chinman, et al., 2014). PSWrs have also been noted to engage in generic duties such as administrative work, teaching skills, and systems-level advocacy (Cronise, Teixeira, Rogers, & Harrington, 2016; Rebeiro Gruhl et al., 2016). A qualitative study using thematic analysis explored how the PSWr role is defined across the 3 different groups of PSWrs, supervisors, and clients (Cabral, Strother, Muhr, Sefton, & Savageau, 2014). Based on the diversity of the literature to date, it is hardly surprising their results revealed a lack of clarity in role definition.

Efforts to maintain pace with the considerable variations in the understanding and implementation of the PSWr role (Chinman et al., 2017) have resulted in research which engages with the numerous configurations of the role (Mahlke et al., 2014). It has been suggested that the lack of a widely accepted typology of their services and work activities may hamper growth in the PSWr field and be responsible for difficulties demonstrating their effectiveness (Rogers & Swarbrick, 2016). A lack of shared expectation about the peer worker role – especially in how lived experience is used – can result in peers feeling unsupported in using their lived experience, potentially eroding peer support values and defaulting to a generic support worker role (Gillard et al., 2015). It has also been purported that facilitating the development of the PSWr role to its full potential requires a more in-depth understanding of experiences in these roles (Byrne, Happell, & Reid-Searl, 2016). Indeed, further research is needed to address the ambiguity of the role which is currently stalling efforts to establish peer support as a legitimate dimension of mental health services. This research aims to ascertain exactly what the PSWr role entails from the experiential perspectives of PSWrs, supervisors, and MHPs.

2.15 Differences and Similarities between PSWrs and other MHPs

It has been asserted that the PSWr role is distinct from that of other MHPs in that PSWr knowledge is derived from personal experience rather than formal training (Fuhr et al., 2014). However the differences and similarities between PSWrs and other MHPs is an area that has been under-investigated. Furthermore, the actual proportion of the mental health workforce with 'lived experience' (personal experience of mental health problems or supporting someone with mental health problems) remains unclear (Leamy et al., 2016). The number of clinician's who work using a dual identity is also unknown

but is acknowledged to be a potential resource in the system, (Gabriel, 2004; Leamy et al., 2016).

A study undertaken by Crane, Lepicki, and Knudsen (2016) aimed to clarify the unique role of PSWr in comparison to that of case managers (CMs). The results revealed a variety of duties and tasks specific to the PSWrs occupation, particularly within the domains of empowering consumers, promoting consumers' educational growth, and supporting personal development. The results also found areas of overlapping responsibility between PSWrs and CMs, including aspects of each role which promote consumers' development, wellness and recovery, administrative tasks, and care coordination activities. Further research is necessary to determine whether the PSWr role offers a unique contribution to mainstream mental health services. This research aims to compare and contrast the role of PSWrs and other MHPs from the perspectives of PSWrs, supervisors, and MHPs.

2.16 Conclusion

Provision of peer support has been widely used to support recovery, yet within the literature, the definition of a PSWr has been only dimly defined. This is commensurate with a general lack of clarity in relation to its principles, role and activities. There is a dearth of literature that explores the differences and/or similarities between PSWrs and MHPs, and whether challenges are inherent to being a peer to a SU. From the literature review no studies have attempted to explore the perspectives of PSWrs, their supervisors and other MHPs in relation to these aspects of the PSWr role. This study aims to fill this gap in the literature.

Integration Peer Support Workers on a Team

2.17 Introduction

The introduction of a new role into an existing team or to complement an existing care pathway constitutes a complex intervention. This section will discuss the factors that support and hinder integration of PSWrs into mental health teams

2.18 Integration of PSWrs into Mental Health Teams

As previously noted, the evaluation of PSWr integration into mental health teams is somewhat limited (Berry, Hayward, & Chandler, 2011). Integration is a process which evolves over time and is therefore based on the combined efforts of the PSWr, the team and the organization (Asad & Chreim, 2016; Mancini, 2018; Moll, Holmes, Geronimo, & Sherman, 2009; Moran et al., 2013; Myrick & Del Vecchio, 2016). Daniels et al. (2010) questioned whether mainstream integration of PSWr services may cause them to conform and loose the essence of their role. Other research raised concern that the value of the PSWr role may be lost through a process of over-professionalisation noting in particular, the use of non-peer supervisors determining peer support roles and responsibilities as a cause for this (Rebeiro Gruhl et al., 2015).

2.18.1 Factors that Support Integration of PSWrs into Mental Health Teams

It has been noted that organizations must have highly developed policies with clear guidelines to support integration of PSWrs (Ahmed et al. 2015; Davidson et al. 2012). Research has pinpointed numerous factors which support integration of PSWrs into teams. These include organisational culture change, organisational readiness, appropriate training of PSWrs, social support, regular supervision, team education in relation to the role, interaction with the PSWr and the PSWrs ability to adjust to their new work environment (Asad & Chreim, 2016; Chinman et al., 2017; Gillard et al,. 2013; Grant et al., 2012; Mancini, 2018; Moll et al., 2009).

Disclosure of the PSWrs lived experience has been noted to be an important factor influencing role integration (Asad & Chreim, 2016). Literature indicates that such

disclosures can have both positive and negative implications for the PSWr, as while it can enable team members to establish rapport with PSWrs (Jacobson et al. 2012) it can also expose these providers to negative perceptions and/or acts of discrimination by team members and staff (Davidson et al., 2012; Gates & Akabas 2007; Lammers & Happell 2003; Moran et al., 2013). It is suggested that PSWrs may be disrespected, silenced, or face exclusion, should non-peer colleagues misunderstand the PSWr role (Mancini, 2018).

2.18.2 Factors that Hinder Integration of PSWrs into Mental Health Teams

A literature review of 18 articles examined PSWrs perceptions and experiences of barriers to implementation of PSWr roles in mental health services. The results indicated that PSWrs found the lack of credibility of PSWr roles, professionals' negative attitudes, tensions with SUs, struggles with identity construction, cultural impediments, poor organisational arrangements, and inadequate overarching social and mental health policies, as the major challenges of being part of a mental health team (Vandewalle et al., 2016). Further obstacles to integration include a lack of clarity regarding the PSWr role giving rise to feelings of exclusion for PSWrs, acceptance of the role, concerns involving self-disclosure, inconsistent training, a lack of supervision, support/self-care, networking opportunities, and a lack of policies and practices around issues of confidentiality (Gates & Akabas, 2007; Kemp & Henderson, 2012; Rebeiro Gruhl et al., 2016). PSWrs may also meet the stigma associated with having a mental health difficulty, as they are employed in the professional setting with the sole aim of 'curing' mental illness (Grant, Reinhart, Wituk, & Meissen, 2012). The persistence of such negativity from non-peer colleagues can result in a lack of role acceptance (Gates & Akabas, 2007; Gillard et al., 2013; MacLellan, Surey, Abubakar, & Stagg, 2015). Moreover it has been noted that peer support workers tended to 'fill service gaps' within intensive, administrative case management environments. The importance of an organisational-wide approach to integrating peer support was emphasised (Gray, Davies & Butcher, 2017). A study investigating the challenges for PSWrs from the PSWr perspective suggested that managers have a responsibility to team members to ensure that peer support workers are included as part of the health team (Kemp & Henderson, 2012). It must be stressed that these studies were small scale qualitative or mix method studies and may not be generalizable.

2.19 Conclusion

Evaluations of PSWr integration into mental health teams are relatively limited. It is recommended that research continue to focus on understanding the factors and contexts which assist PSWr integration to ensure they can do the work prescribed by their role (Asad & Chreim, 2016; Dark, Patton, & Newton, 2017; Mancini, 2018; Silver & Nemec, 2016). As far as the author is aware, no studies to date examined this area from the perspectives of PSWrs their managers and MHPs. This research aims to examine the factors that both support and impede integration of PSWrs into clinical teams from the perspectives PSWrs, supervisors, and MHPs.

PSWr Impact on Mental Health Team Members and Organizations

2.20 Introduction

Adding PSWrs to mental health teams can have an impact on the team members and on the organisation itself. This section aims to explore both the positive and negative impact of PSWr involvement.

2.21 PSWr Involvement on Teams

2.21.1 Positive Impact of PSWr Involvement on Teams

Research suggests PSWrs are both advocates and agents of change within mental health services and are thought to effect particular change on system-level activities (community planning, public education, advocacy, and action research) (Mancini, 2018). It is proposed that integrating the PSWr role can add value to the mental health team/organisation due to the authenticity of the role (Rebeiro Gruhl et al., 2016). It has been suggested that the addition of such peers can improve the overall success of clinical teams (Chinman et al., 2014). It is purported that PSWrs recognize and are able to disrupt practices within mental health organisations which are deemed to be stigmatising (Mancini, 2018). The UK ImROC programme maintains that the PSWr role can challenge negative attitudes of staff and acts as an inspiration for all team members (Trachtenberg et al., 2013). It must be noted that while it may be somewhat taxing for PSWrs to be consistently perceived as the "poster children" for recovery, research has shown that teams can be made more successful through the experiential knowledge made available by their inclusion (Chinman, et al., 2014; Gillard & Holley, 2014; Gordon & Bradstreet, 2015; Mahlke et al., 2014). PSWrs can also improve team information-sharing with SUs and can promote a better understanding of the challenges clients face (Coatsworth-Puspoky et al., 2006).

2.21.2 Negative Impact of PSWr Involvement on Teams

In contrast it has been argued that the implementation of peer support services may present a specific set of challenges to organisations as it fundamentally contests the traditional way community mental health organisations interact, treat, and respond to SUs (Mancini, 2018). A study investigating the impact of peer support working on teams found that flexible working arrangements for PSWrs had the unintended

consequence of perpetuating hierarchies within teams (Gillard et al., 2013). However, this study was a secondary analysis of qualitative data and therefore deemed not to be a good fit between the data collected in the primary study and the questions asked of the data in the secondary analysis. Despite the suggested power of PSWrs in influencing organizational change, research in this area is lacking and needs more investigation (Rebeiro Gruhl et al., 2016; Trachtenberg et al., 2013).

2.22 Conclusion

The inclusion of PSWrs on mental health teams can exert both a positive and negative impact. Further research is needed across a full range of relevant stakeholders (Gillard et al., 2013) to evaluate the extent to which the presence of PSWr challenges aspects of the existing culture, values, and practice of the team (Silver & Nemec, 2016) As far as the author is aware, no studies have attempted to explore the perspectives of PSWrs, their supervisors, and other MHPs in relation to the impact of involvement of PSWrs on mental health team members and services/organisations.

Impact of Peer Support Workers Working with Service Users (SUs)

2.23 Introduction

This section will firstly discuss factors that contribute to the success of PSWrs working with SUs. Following this it will then comment on the research evaluating outcomes of PSWrs working with SUs.

2.24 Impact of Peer support working on SUs

There has been relatively little high quality research into the effectiveness of the PSWr role for SUs (Trachtenberg et al., 2013) with a notable bias toward publications of English language research. It has been suggested that the provision of services appears to be outpacing supporting evidence (Pitt et al., 2013).

2.24.1 Factors that Contribute to the Success of PSWr working with a SU

A recent literature review on peer support mechanisms, processes, and relationships with SUs, identified five notable mechanisms:

1. lived experience
2. love labour
3. the ambiguity of the position of the peer worker
4. strengths-focused social and practical support
5. the helper role (Watson, 2017)

Gillard, Gibson, Holley, and Lucock (2015) identified key mechanisms of change for SUs to include:

1. building trusting relationships based on shared lived experience
2. role-modelling individual recovery and living well with mental health problems
3. engaging SUs with mental health services and the community

Salzer (2002) also reviewed several theories to explain the impact of PSWrs as follows:

Table 4: Theories to explain the impact of PSWrs (adapted from: Salzer, 2002)

Festinger, 1954	social comparison theory	comparing oneself to similar others can improve hope and motivation
Bandura, 1977	social learning theory	behaviour change can be enhanced when modelling from similar others
	social support theories	PSWrs can provide emotional aid, concrete assistance, information, companionship, and validation
Borkman, 1999	experiential knowledge	PSWrs can share details from their own experience to facilitate recovery
Riessman, 1965; Skovholt , 1974	the helper-therapy principle	PSWrs also experience enhanced competence and wellbeing from helping others

2.24.2 Outcomes of PSWr Working with SU

A number of systematic and non-systematic literature reviews have collated evidence on the employment of peer workers in mental health services with mixed results (Bellamy, Schmutte, & Davidson, 2017; Chinman et al., 2014, 2017; Davidson, 2012; Davies, Gray, & Butcher, 2014; Fuhr et al., 2014; Holley et al., 2015; Lloyd-Evans et al., 2014; Miyamoto & Sonon, 2012; Davidson, 2012; Pitt et al., 2013; Repper & Carter 2011; Vandewalle et al., 2016; Walker & Bryant 2013; Warner 2009). However, these reviews cut across study types and compare SUs receiving standard care with or without unstructured PSWr support and SUs receiving a structured curriculum delivered by PSWrs. Furthermore, several of these studies suffer from methodological shortcomings, including small sample sizes, untested outcome measures, non-blind data collectors, self-reported data, and non-randomized research designs. Some reviews have reported a number of benefits for SUs:

Table 5: Some benefits for SUs (Chinman et al., 2014; Davies et al., 2014; Fuhr et al., 2014; Holley et al., 2015)

Feeling more knowledgeable	confident and happy	A reduced sense of social isolation	improved quality of life	increased community tenure	higher levels of empowerment
increased sense of independence and empowerment	reduced inpatient service use	improved relationship with providers	better engagement with care	higher levels of patient activation	higher levels of hopefulness and motivation for recovery

Although some studies have reported peer services to be effective at reducing hospitalisation rates and symptom severity, this has not been found consistently (Bellamy et al., 2017). Findings from two systematic reviews on PSWr interventions for physical health and lifestyle behaviour for people with severe mental illness indicated that mixed and limited intervention effects were reported for most health outcomes. It must be noted that the strength of the evidence generated from these studies is limited due to several methodological issues. (Cabassa, Camacho, Vélez-Grau, & Stefancic, 2017; Stubbs, Williams, Shannon, Gaughran, & Craig, 2016). Cross-sectional and longitudinal studies reveal that SUs receiving peer support have shown improvements in community integration and social functioning (Chinman et al., 2001; Yanos et al., 2001; Forchuk et al., 2005; Nelson et al., 2006; Huxley et al., 2005; Lawn et al., 2008).

Trials to date have provided inconsistent results. Two recent meta-analyses (Lloyd-Evans et al., 2014; Pitt et al., 2013) found very little impact of PSWrs. However, these studies only considered randomized trials and grouped together small numbers of studies of PSWr interventions that varied from each other; all of which likely affected the ability to detect outcomes. The deficiencies in the conduct and reporting of these trials typify the difficulties inherent in the evaluation of complex interventions (Chinman et al., 2014; Lloyd-Evans et al., 2014). A recent randomized controlled trial comparing one-to-one peer support with established treatments for severe mental illnesses found that SUs in the intervention group had significantly higher scores of self-efficacy at the six-month follow-up. There were no statistically significant differences in

quality of life, social functioning, and hospitalizations in the intention to treat analyses. The findings suggest that one-to-one peer support delivered by trained peer supporters can improve self-efficacy of patients with severe mental disorders over a one-year period (Mahlke et al., 2017).

Despite considerable research into the effectiveness of peer workers in working with SUs, there is insufficient evidence supporting the proposition that a substantial peer workforce would necessarily improve the outcomes of people living with mental illness (O'Connor, Clark, & Ryan, 2017). More research is needed to determine when, why, and for whom PSWrs have a positive impact, and which types of PSWrs have the most positive effect.

2.25 Conclusion

This literature search and review did not discover any investigations into the perceptions of PSWrs, supervisors, and MHPs in relation to the impact of the PSWr on SUs. Furthermore, no research has investigated the challenges which PSWrs face when working with SUs from the perspective of PSWrs, supervisors, and MHPs. This study also aims to address these gaps.

Impact of Peer Support Workers Role on the Workers Themselves

2.26 Introduction

This section aims to explore the PSWr's experiences of the PSWr role and the impact of the role on their personal recovery.

2.26.1 PSWr Experiences of the Role

Understanding the experiences of PSWrs is essential for improving employment practices. Employees in general can experience feelings of uncertainty when starting a new position (Teboul & Cole, 2003). This feeling of uncertainty may be intensified for PSWrs as it is also a new role within an organisation which lacks former role models and established norms (Grant et al., 2012). The factors that make PSWrs unique and effective may also be the factors that contribute to confusion and apprehension which PSWrs frequently experience in their role on a mental health team (Mancini, 2018). It has been proposed that the level of PSWr job satisfaction is relative to the clarity, autonomy, respect and supervisor understanding of job role (Cronise et al. 2016; Davis, 2013; Kuhn et al., 2015; Mancini, 2018). A systematic review evaluating job satisfaction outcomes for PSWrs employed in mental health settings revealed that PSWrs are generally satisfied in their work settings and contributions to this included the work environment and employers, employment factors, and collaborative approaches (Chappell, Deckert, & Statz-Hill, 2016).

A meta-synthesis of qualitative studies examined and critically compared the experiences of PSWrs, their non-peer colleagues, and SUs who received peer support, from 27 published studies. Highest frequency findings found challenging experiences to include non-peer staff discrimination and prejudice, low pay and long hours, and difficulty managing the transition from "patient" to practitioner. The more positive experiences of PSWrs included collegial relationships with non-peer staff, other peers and increased wellness secondary to working (Walker & Bryant, 2013). However, of the studies reviewed, only four actually explored the experiences of SUs receiving peer support services, and due to the predominantly qualitative nature of these studies, the generalizability of the findings is questionable.

2.26.2 Impact on PSWr role on the PSWr: Personal Recovery

Research suggests being employed as a PSWr has a number of benefits for the employee themselves. It has been found that PSWrs feel more empowered in their own recovery journey, have greater confidence and self-esteem, feel more valued and less stigmatised, and have a more positive sense of identity (Mowbray et al., 1998; Salzer & Shear, 2002; Repper & Carter, 2011). However, the potential to relapse due to stress of the PSWr role is a concern for both non-peer colleagues and PSWrs alike (Manning & Suire, 1996; Nikkel et al., 1992).

A systematic review of qualitative research on the impact of working as a PSWr on personal recovery reported that the role had the potential to be both facilitative of and detrimental to personal recovery. However, it further noted that the quality of relevant existing studies included varied widely (Bailie & Tickle, 2015). Another systematic review of qualitative studies on the impact of the PSWr role on the peer revealed that the factors which impacted on the peer worker positively included core constructs, such as reframing identity through reciprocal relations, the therapeutic use of self, and enhancing responsibility (MacLellan et al., 2015). It must be noted that due to the qualitative nature of the studies in the review, generalizability is also limited in this instance.

Lived experience of having a mental illness is fundamental to the PSWr role, and thus, the PSWr identity (Simpson et al., 2017). Research suggests that PSWrs have to cope with challenging and opposing dynamics within and outside themselves. A conceptual framework developed from grounded theory suggests that the PSWr role has the potential to threaten (detrimental consequences in relation to mental illness) and safeguard (using ones lived experience provided the opportunity to enhance personal recovery) their need for self-preservation (Debyser, Vandewalle, Vandecasteele, & Verhaeghe, 2017). A further conceptual framework developed from grounded theory revealed participants constructed their identity situationally as a means to separate "professional" and "patient" identities, and "migrated" between identities as the context required. Participants also demonstrated personally valued "integrated" identities in relation to some professional contexts. Positive identity purports the integrated experiences of an SU and a professional included "personhood" and insider "activist," drawing in turn on discourses of "personal recovery," "lived experience," and "use of self" (Richards, Holttum, & Springham, 2016). A grounded theory study revealed

PSWrs realise meaningful employment by using their lived experience perspective as an asset, liberate themselves from restrictive role patterns, and break down stigma and taboo. The conceptual framework derived from this asserts that peer workers strive towards constructing a positive identity and are driven by a desire for normalization and instinct for self-preservation (Vandewalle et al., 2018).

In light of the limited research to date, high-quality research has been called for, to specifically investigate the effects of employment as a PSWr on personal recovery (Bailie & Tickle, 2015).

2.27 Conclusion

Research findings reveal that being employed as a PSWr can be both a positive and challenging experience. To date, no known research has compared the perspectives of PSWrs, supervisors and MHPs in relation to the impact of the PSWr role on the PSWr themselves.

Training of PSWrs

2.28 Introduction

This section will explore the research on the training for PSWrs and specifically comment on the positive and negative aspects of PSWr training.

2.29 Training for PSWrs

Commentators agree on the need for the development of training curricula for PSWrs (Rivera et al., 2007) based on the principles of peer support (Trachtenberg et al., 2013). Wide variability has been found in the descriptions of PSWr training across numerous reviews (Cabassa et al., 2017; Chinman et al., 2014; Lloyd-Evans et al., 2014; Pitt et al., 2013) arguably due to the wide range of actual PSWr roles. Research conducted to date provides few firm details of the strategies and methods used to supervise PSWrs to ensure fidelity of the interventions being evaluated (Cabassa et al., 2017). Future studies would benefit from a clearer delineation of the relevant content and implementation of training for the role. As the PSWr role relies on the individuals lived experience, training requires careful thought to ensure the well-being of individuals and the future success of peer support initiatives (Simpson et al., 2017). It must be cautioned that training should not take away the value of peer support through a process of over-professionalising the peer workforce (Rebeiro Gruhl et al., 2015). The approach to training should not send the message that knowledge learned takes priority over lived experience. Moreover, a formalised language of peer support might distance PSWrs from SUs (Gillard et al., 2017).

The UK National Institute for Health Research-funded programme (ENRICH) has created a framework specifically designed to inform the writing of the training that peer workers will receive, and the supervision and support they are offered at individual, team and organisational levels. It also aims to support the development and evaluation of one-to-one PSWr roles in mainstream mental health care guiding. The testing of the ENRICH principles-based fidelity index is currently underway (Gillard et al., 2017).

2.30 Negative and Positive Aspects of PSWr Training

It is indeed difficult to understand how PSWrs are expected to demonstrate expertise in areas of recovery and support with limited training, and by mainly drawing on their

unique lived experience (Cronise et al., 2016). It is clear that the PSWr role can be stressful, particularly if they receive inadequate training, supervision and support (Yuen & Fossey, 2003). It has also been found that PSWrs feel the assimilation of large volumes of complex lecture material difficult (Meehan et al., 2002). It has been suggested that training should include a combination of classroom and experiential components (Cournos & Goldfinger, 2014; Meehan et al., 2002) which instruct PSWrs in what to disclose to clients, and with issues of self-care (Chinman et al., 2008; 2017). However, providing a standardised peer support training has the potential to formalise, or professionalise peer support (Faulkner & Bassett, 2012), but is also puzzling as they are being ask to "work and train at being authentic" (Scott, 2011). Beneficial attributes of training have been found to include an increase in knowledge (Salzer et al., 2009), satisfaction with the content, relevance of the classroom component (Meehan et al., 2002), the usefulness of communication and counselling skills (Bentley, 2000; Meehan et al., 2002), an increase in clinical capacity, and an expansion in mental health coverage (Rebello et al., 2014). No research to date has explored and compared the views of PSWrs, supervisors, and MHPs in relation to the usefulness of the training for PSWrs.

2.31 Conclusion

Minimal research has reported on the training for the role of PSWr. To the best of the author's knowledge, no studies to date have attempted to explore the perceptions PSWr training from the perspectives of PSWrs, their supervisors, and other MHPs.

Current Study

2.32 Introduction

The aim of the present section is to outline and provide a rationale for the present study, presenting the study's aims and research questions.

2.33 Rationale for current study

This study, rather than investigating effectiveness, steps back in order to explore the complex mechanics of PSWrs earliest involvement, to shed light on integration and operational difficulties, and address the improvements necessary to bring about changes to the benefit of the overall mental health clinical service and all individual SUs. This study investigates the PSWr role from multiple perspectives comparing the perspectives of PSWrs, their supervisors and other MHPs to paint a holistic qualitative picture of the PSWr role at an early stage in their employment which is conspicuously absent in the research to date through the following topics (Table 6):

Table 6: Topics for exploration across groups

Meanings	
1.	What does personal recovery mean?
2.	What does 'peerness' mean?
Peer support work	
3.	What do PSWrs do?
4.	What integrates PSWrs into a mental health team?
5.	Was PSWr training adequate for their role?
6.	What is important moving forwards with the role?
Impact of peer support	
7.	What is the perceived impact of the PSWr role on teams?
8.	What is the perceived impact of the PSWr role on SUs?
9.	What is the perceived impact of the PSWr role on the PSWrs themselves?

2.33.1 Recovery

Recovery is a complex and multifaceted concept. From the extensive literature review conducted it emerged that no studies have attempted to explore the perspectives of PSWrs, supervisors, or MHPs in relation to the definition of recovery or to elicit their opinion of the most important aspects.

2.33.2 Peerness

Research is scarce in terms of what constitutes a 'peer' which are most important aspects to form a connection between PSWrs and SUs, in a mental health setting. From the literature review conducted it emerged that no studies have attempted to explore the perspectives of PSWrs, supervisors, or MHPs in relation to the definition of peerness or to elicit their opinion of the most important equivalent experiences.

2.33.3 Peer Support Worker Role

Provision of peer support has been widely used to support recovery, yet within the literature, the definition of a PSWr has been only dimly defined. This is commensurate with a general lack of clarity in relation to its principles, role and activities. There is a dearth of literature that explores the differences and/or similarities between PSWrs and MHPs, and whether challenges are inherent to being a peer to a SU. From the literature review no studies have attempted to explore the perspectives of PSWrs, their supervisors and other MHPs in relation to these aspects of the PSWr role.

2.33.4 Integration Peer Support Workers on a Team

Evaluations of PSWr integration into mental health teams are relatively limited. It is recommended that research continue to focus on understanding the factors and contexts which enable PSWr to integrate into clinical teams and perform their role most effectively. As far as the author is aware, no studies to date examined the perspectives of PSWrs, their supervisors, and other MHPs in relation to the impediments and supports of PSWrs integration into mental health teams.

2.33.5 PSWr Impact on Mental Health Team Members and Mental Health Organisations

The implementation of PSWr policies also present a specific set of challenges to organizations as they conflict with the established way in which mental health organisations interact, treat, and respond to SUs. The inclusion of PSWrs on mental health teams can exert both a positive and negative impact on team members. As far as the author is aware, no studies have attempted to explore the perspectives of PSWrs,

their supervisors, and other MHPs in relation to the impact of involvement of PSWrs on mental health team members and services/organisations.

2.33.6 Impact of Peer Support Workers Working with Service Users

Despite considerable research into the effectiveness of peer workers in working with SUs, there is insufficient evidence supporting the proposition that a substantial peer workforce would necessarily improve the outcomes of people living with mental illness (O'Connor, Clark, & Ryan, 2017). More research is needed to determine when, why, and for whom PSWrs have a positive impact, and which types of PSWrs have the most positive effect. From the literature review conducted it is evident that no studies have so far attempted to explore the perceptions of the impact of PSWr role on SUs from the perspectives of PSWrs, their supervisors, and other MHPs.

2.33.7 Impact of Peer Support Workers role on the worker themselves

Research findings reveal that being employed as a PSWr can be both a positive and challenging experience. From the literature review conducted it is evident that no prior studies have attempted to explore the impact of the PSWr role on the workers personal recovery from the perspectives of PSWrs, their supervisors, and other MHPs.

2.33.8 Training of the PSWr

Minimal research has reported on the training for the role of PSWr. To the best of the authors knowledge, no studies to date have attempted to explore the perceptions PSWr training from the perspectives of PSWrs, their supervisors, and other MHPs.

2.34 Conclusion

This study aims to address the basic issues pertaining to the involvement of PSWrs in mental health teams and the relevant gaps in the research date as outlined above. It also aims to elicit and compare the views and experiences of PSWrs, their supervisors, and other MHPs in relation to the employment of PSWrs on mental health teams.

Chapter 3: Methodology

3.1 Introduction

Chapter 3 presents the methodological approach used in the current study. It will discuss the ontological and epistemological stance of the researcher, the aims of the research, research design and method. It will also provide an overview of the services, demographic details of the participants, Peer Support Workers (PSWrs) training, research procedure, data collection and analysis and reflexivity of the researcher.

3.2 Ontology of the researcher

The researcher holds the ontological position of critical realism. The assumptions of critical realism suggest that there is a real and knowable world subsumed beneath multiple subjective and socially-located perspectives. In other words, critical realism posits an authentic reality which enables research to produce knowledge which might make a difference (Braun & Clark, 2013; Rogers & Rogers, 1997).

3.3 Epistemology of the researcher

The researcher holds the epistemological position of contextualism. Contextualism does not assume a single reality, but rather sees knowledge as emerging from context. However, it does have an interest in understanding truth in so far as it accepts that no single method can definitively locate truth but that knowledge can be true (valid) in certain contexts.

3.4 Aim of the research

The aim of the research was to explore and compare the views and experiences of Peer Support Workers (PSWrs), Supervisors, and Mental Health Professionals (MHPs) regarding the inclusion of PSWrs in mental health teams on a number of topics. The evaluation collected data across pilot sites in order to determine key learnings for the future employment of PSWrs within statutory mental health services.

3.5 Research design

An exploratory and comparative qualitative research design was used for this study. The introduction of a new role into an existing team, or to complement an existing care pathway, constitutes a complex intervention for which systematic feasibility and piloting work in both development and evaluation are a necessity (Gillard et al., 2015). Furthermore, given the paucity of research in this particular area, an exploratory qualitative approach was deemed most appropriate to derive meaning, examine processes, understanding, descriptions and perceptions. Exploration of cognitions, felt experiences, and generation of ideas were additional inducements to employ this method (Averill, 2014; Rohleder & Lyons, 2015; Starks & Trinidad, 2007).

Triangulation was used to compare multiple perspectives in order to develop a comprehensive understanding of relevant phenomena (Patton, 1999). As with all qualitative designs the overarching approach incorporates the following phases: data generation; data display; data reduction; data analysis and interpretation (meaning-making/conclusion-drawing); assuring the integrity, transparency, and accuracy of all activities; and findings and dissemination (Averill, 2014).

3.5.1 Thematic Analysis Methodology

Upon consideration, a 'thematic analysis' (TA) was selected as the most appropriate approach to answer the research questions. TA is a qualitative method frequently used to identify, analyze, and interpret the 'patterned meanings' or 'themes' within a dataset (Braun & Clarke, 2006; 2013). Patton (2002) purports that the thematic analysis of data generates a logical and cohesive chain of evidence which may educe theoretical conclusions (Patton, 2002). It is worth noting that while other approaches to qualitative analysis offer theoretically sound frameworks for collecting and analyzing data, thematic analysis differs in that it only specifies analytical procedures centered on coding and theme development (Braun, Clarke, & Terry, 2015). Nevertheless, there was judged to be a 'goodness of fit' between the methodology to be adopted for data collection and subsequent thematic analysis.

As thematic analysis addresses the occurrence of patterns within data this approach was chosen over other qualitative approaches such as Interpretative Phenomenological Analysis (IPA) and Grounded Theory (see Smith et al., 2015). Both IPA and Grounded

Theory also aim to seek patterns in the data but are theoretically bound (Braun and Clarke, 2006). The IPA approach places particular focus on the voice of the individual and how they 'make meaning' of their experience, rather than concentrating on the patterns of responses which exist across broad datasets. The current research was focused on exploring three different groups' perceptions, and as such, did not seek to explore any single client experience in significant depth. For this reason, an IPA approach was not deemed suitable for the present study. Moreover, Grounded Theory seeks to develop a substantive theory to provide a deep explanation for a situation which was not the goal of this study.

Overall as thematic analysis does not require the detailed theoretical and technological knowledge of approaches such as IPA and Grounded Theory; however, it offers a more accessible form of analysis which can generate findings which are easily disseminated. As this research aims to be practice-relevant, this particular feature was deemed a valuable characteristic and was the reason why thematic analysis was employed.

3.6 Method

3.6.1 Semi-structured interview

The semi-structured interviews used as the method of data collection in this study elicited rich and detailed information regarding how individuals experience, understand, and explain their answers to the research questions. Semi-structured interviews are flexible and allow for the discovery and elaboration of areas that are thought of as important during the interview.

The rationale for using interviews rather than a standardised survey was that interviews afford participants greater opportunities to provide the detail and depth which allows insight into how individuals understand and narrate aspects of their lives. Additionally, interviews can be tailored to the knowledge and experience of the interviewee. More specifically, semi-structured interviews ensure that all interviewees address the same questions, and that ensuing responses can be directly compared. Furthermore, more structured interviews increase the generalizability of the overall research findings.

Structured interviews are similar to a survey but are verbally read aloud to the participant. It was felt structured interviews would again provide no scope for follow-up questions to responses that warrant further elaboration and are of little use if more depth and detail are required.

Although focus groups share the features of semi-structured interviews, they seek to generate information on collective views and the meanings, which was not the goal of this study. Moreover, it was felt that participants may not be able to talk freely in a focus group, especially in relation to sensitive and challenging topics and as a result semi-structured interviews were deemed more appropriate (Gill, Steward, Treasure & Chadwick, 2008).

3.7 Services

3.7.1 The Health Service Executive

The Health Service Executive (HSE) is an organization comprised of more than 100,000 people, with the remit to direct and administrate all public health services in Ireland. Their mission is to place clients at the centre of the organisation and to manage services in such a way as to best facilitate this aim. To this end, the HSE Code of Governance, first approved by the Minister for Health and Children in 2007, provides an overview of all relevant principles, policies, procedures and guidelines. The HSE directs functions and manages the business on the basis of this code which also is intended to guide the Directorate, leadership teams, and all those employed both within the HSE and all subsidiary agencies funded by the HSE, to perform their duties to the highest standards of accountability, integrity and propriety.

3.7.2 Details of the services who took part in this study

The study took place in a range of HSE settings around Ireland in which services were being provided for adults suffering from non-specific mental health conditions. The PSWrs, Supervisors, and MHPs who participated in this project were therefore located across a range of diverse service and geographical settings.

3.8 Participants

3.8.1 Sampling Strategy

Four mental health services were involved in the pilot of the employment of PSWrs. This convenience sample was naturally constrained due to the host services.

3.8.2 Inclusion Criteria

PSWrs, Supervisors, and MHPs employed on the mental health teams which formed part of the pilot project were eligible for inclusion in the study. The written consent of all participants was required.

3.8.3 Demographics of Participants

A total of 12 participants took part in this study. Each PSWr employed on an individual team agreed to take part in the interviews (N=4; M:F= 2:2). All had been working in the service for 8 months. The supervisors of the PSWrs agreed to take part in the interviews (N=2; M:F=1:1). All MHPs were also invited to take part in the study. From the group who were interested, six were randomly selected to participate (N=6; M:F=2:4). The professional role of the 6 MHPs who took part in this study included psychiatry (n=1), social work (n=1), nursing (n=2), clinical psychology (n=1) and occupational therapy (n=1). These MHPs had been qualified for a mean of 5.5 years and had been working in the service from 3 to 6.5 years (M=4.5; SD=1.36). Detailed demographic information of participants is presented in Table 7.

Table 7: Demographic Information of Participants

Group	Total N	Age Range (years)	Mean age (SD)	Male: Female
Total group	**12**	**25-54**	**39 (8.86)**	**5:7**
Peer support workers	**4**	**25-54**	**36 (12.57)**	**2:2**
Supervisors	**2**	**39-49**	**44 (7.07)**	**1:1**
Mental health professionals	**6**	**32-53**	**39.33 (7.12)**	**2:4**

3.9 Peer Support Workers

3.9.1 Description of PSWr role

PSWrs are individuals with their own 'lived experience' of mental health difficulties who are employed in mental health services to bring their unique expertise to the service. Like other professionals PSWrs may only be employed when confirmed to be in a current stage of recovery which enables them to properly fulfil the role. PSWrs provide support to service users and can be involved in work such as linking service users with other sources of support, aiding the service user in community engagement, discussing and helping them to formulate their own goals, and by providing solidarity and practical support around achieving these goals. PSWrs can also act as 'beacons of hope' for people experiencing distress, and engage with individuals and families struggling to mediate with other mental health professionals. This role is in keeping with the broader HSE policy of incorporating the voice of service users and it is hoped that their introduction will further enhance team focus on the service user perspective. As full members of the multidisciplinary teams (MDTs) PSWrs attend MDT meetings, carry an appropriate caseload, and are included in service-related discussions.

3.9.2 Peer Support Worker Training

A national standardised training programme for PSWrs was provided by Dublin City University (DCU), School of Nursing. This training programme is a level 8 HETAC qualification. It consisted of three 2-week teaching blocks in between two 5-week trainee clinical placements carried out in their host service. Programme Philosophy is underpinned by: intentional emancipatory education; utilisation of lived experience; a facilitated (as opposed to didactic) learning process; and the pursuit of practical wisdom. The pedagogical approach is 'co-operative learning', one that has been developing in the School since 2007 and applied to a number of modules, courses and programmes. Transformative Education & Lived Experience (TELE) http://www.dcu.ie/snhs/tele.shtml is an overarching framework in the School that encompasses this philosophy and pedagogical approach.

The programme comprised of three separate though interrelated modules of 10 credits each (Appendix L). Each module had particular learning outcomes, knowledge and

skills development, incrementally designed to culminate with each student meeting the overall programme learning outcomes (Table 8).

Table 8: Learning outcomes of the training programme

1	Have knowledge of latest trends and developments nationally and internationally in recovery orientated mental health practice. Have knowledge of the historical, statutory and policy framework in which the Irish Mental Health Service operates.
2	Understand the core principles of the individualised nature of recovery and a person-centered approach; and the core principles, competencies and practices of peer support working.
3	Understand and be able to apply the core principles of recovery in a peer and multidisciplinary team setting.
4	Work across a client's full domain of supports including family and natural supports.
5	Understand and apply the role of a professional Peer Support Worker in a mental health service and community setting.
6	Work in a collaborative and interagency way with diverse stakeholders as part of a multidisciplinary team; and evaluate and reflect on personal effectiveness when communicating with other health care personnel.
7	Be able to engage in reflective practice, supervision and support structures to maintain fidelity to the role of professional peer support working.
8	Utilise their lived experience of mental health distress and recovery in an appropriate manner to work alongside others with a similar experience in a manner that is solution focused and goal striving.

This blended learning programme aimed to develop individual's knowledge and skills to be able to integrate with and work fully as a PSWr in a statutory mental health service. Teaching was delivered through a blend of classroom, practice and online learning methods. As requested by HSE and DCU, trainees were continually assessed across modules to maximise learning and ensure programme outcomes are achieved. These included: peer assessment, case study write up, feedback loops from supervisors and clients, class room presentations of work in progress, reflective diaries and reflective practice portfolios.

3.9.3 Peer Support Worker Supervision

Support and supervision was provided through two processes in addition to personal tutors being allocated to each student. The first process was peer facilitated group supervision, which occurred 6 times during training and aimed to facilitate peer support,

reflection on challenges and collegial learning. The second process was one of tripartite supervision, formative, restorative and normative, consistently used by the School of Nursing & Human Sciences to provide support in practice, whilst engaging in an assessed educational process (Kadushin, 1992; Proctor, 1987). Each student was also allocated an academic supervisor (an Expert by Experience or Academic who consistently works in partnership with Experts by Experience) and a practice supervisor who were senior MHPs from their mental health team with a professional background in Social Work who provided dedicated time to line manage and supervise PSWrs. Through the support of these 3 people, the programme aimed to provide a supportive and reflective process of learning and practice development. In addition, as per the model applied in the School, each person contributed to the assignment marking in practice portfolios.

3.10 Research Procedure

The design, method and procedure of the study, was developed in accordance with the Code of Ethics for the Psychological Society of Ireland (PSI). As such, it entailed the preparation of numerous tasks including receiving ethical approval, recruiting participants, and assuring the confidentiality and anonymity of participants.

3.10.1 Ethical Issues and Approval

All participants participated in this research voluntarily and no inducements or incentives were provided for participation. All the PSWrs and MHPs who participated in this study gave their informed consent for their data to be used in the study (Appendix C). Given the relatively small sample size involved in this study and the fact that participants were employees of the HSE, every effort was made to ensure anonymity whilst at the same time remaining true to the data generated. The emotional well-being of the participants in the study was consciously and diligently prioritised throughout the research process and the researcher remained vigilant for signs of distress and was sensitive in her approach at all times. Participants were informed of their right to discontinue and withdraw from the study at any time during the testing session. It was explained however, that following the conclusion of the data collection phase they would be unable to withdraw individual contributions, since data would then be unidentifiable. Participants were additionally informed that they would be asked to

confirm that they were comfortable for the transcription of everything discussed upon completion of the interview. If not, participants could instruct the researcher of any part they wished to exclude. This study was granted ethical approval by a HSE Research Ethics Committee (REC).

3.10.2 Recruitment and invitation to participate

Each team involved in the pilot was given an overview of the research at a convenient date and time organised approximately three months prior to the commencement of the research. The nature of the study was explained in a clear and accessible manner and attendees were also provided with information sheets (Appendix B). It was stressed that the interview did not seek to 'evaluate' peer work against a given standard, but rather was a method of understanding, ascertaining experience, and describing its implementation. Opportunities to ask further questions regarding the research was also provided. Interested individuals then completed an "expression of interest" form (Appendix A) which gave permission for them to be contacted to participate in the study.

3.10.3 Confidentiality, Anonymity and Consent

On the day of the interviews, participants were again provided with information sheets and an opportunity to ask questions regarding the research (Appendix B). Confidentiality and anonymity in the research process was once again assured. The participants were informed that an audio recorder would be used for interviews. It was explained that until the time of transcription this device would be kept in a locked drawer in a HSE service and be accessible only to investigators throughout the research period. It was made clear that all data would be transcribed as soon as possible following collection and thereafter remain on a password protected file on a password protected computer.

All interview recordings were deleted following transcription and participants were guaranteed that their personal details would be anonymized during this process by the assignment of a number in place of their names. Participants were informed that only the principal researcher, the research supervisor, and the thesis examiners would have access to transcribed data. They were also informed that the UL School of Psychology

experts in the qualitative analysis of transcribed data may be used for consultation should the need arise.

Finally participants were informed that the password protected data would be kept for ten years to allow for publications and then be destroyed in an appropriate manner. Following this, those who agreed to take part were asked to sign a consent form indicating that they understood the aims and objectives of the research and that they had been given adequate opportunities to have any questions answered. If participants agreed to take part, they completed a consent form (Appendix C).

3.11 Data collection

3.11.1 Development of interview schedule

This study used an interview schedule with structured questions to allow systematic comparisons across cases. The development of the semi-structured interview schedule was an iterative process undertaken in several phases of design, review and revision. An initial set of items were derived from the existing knowledge base. A number of questions were revised following discussion between the principal researcher and the research supervisors (Appendix D).

3.11.2 Interview procedure

Interviews took place in private rooms in a range of adult mental health service settings. At the outset of the interview, participants were once again reminded they would be recorded for accuracy and asked to confirm they were comfortable with this. All participants granted their permission. It was also pointed out that participants were not obliged to answer any questions which made them uneasy and every attempt was made to create a warm and comfortable atmosphere during the interview. All participants were encouraged to take breaks as they felt necessary.

Each interview was conducted face-to-face, lasted approximately 45 minutes to 1 hour and 30 minutes, and followed the semi-structured interview schedule. While consciously conducted at the participants' pace, the interviews generally adhered to the format of the schedule. Participants were occasionally asked to clarify their answers through the addition of more probing questions (Appendix D).

3.11.3 Field Memos

Field memos were taken post the entire interview process in order to document additional information as it is suggested that "all data", and anything you learn in the research setting(s) or about your research topic, can serve as data (Charmaz, 2006). As such, the field memos included participant remarks made to the researcher when the audio recorder was turned off and behavioural observations of participants during the interview (Appendix E).

3.11.4 Debrief/support following interview

Time was allocated at the end of each interview to permit debriefing and to allow participants the opportunity to revisit any issues that may have arisen during the interview process. The participant was also advised that should they come to experience distress at any time in relation to the study, to contact the researcher, the research co-ordinator, or the Employee Assistance Programme provided by the HSE to avail of support and information on further services available.

3.12 Method of Data Analysis

3.12.1 Thematic Analysis procedure

Data from twelve in-depth qualitative semi-structured interviews were analyzed using a Thematic Analysis (TA) method. All interviews were transcribed verbatim by the author and all participant identifying details were also anonymized at this stage. The data analysis followed the guidance of Braun and Clarke (2013) to address the various research questions as shown in Table 9.

Table 9: Phases of Thematic analysis (Braun & Clarke, 2013)

Phases:
1. Transcription 2. Reading and familiarization; taking note of items of potential interest 3. Coding- complete; across entire data set 4. Searching for themes (Candidate themes) 5. Reviewing themes (producing a map of the provisional themes and subthemes and relationship between them aka the thematic map) 6. Defining and naming themes 7. Writing- finalizing analysis

The TA method facilitated the identification of themes which related to the evaluation objectives. The analysis looked for similarities and contrasts in the perspectives of different participant groups; the PSWrs, supervisors and MHPs.

3.12.2 Validity in analysis

Investigator triangulation was conducted on random segments of the research to test validity. The inter-rater convergence of themes ensured the analysis was robust. This second coder was my supervisor, a Doctor of Psychology and lecturer, based in a third level institution in Ireland. They have an extensive background in research methodology and have familiarity with qualitative approaches and analysis, and as a result were deemed to be a suitable candidate for coding.

3.13 Reflexivity of the researcher

Qualitative research uses the researcher as a central and valuable tool in the analytical process (Averill, 2014; Braun & Clarke, 2013; Patton, 1990). Reflexivity is regarded as an essential requirement of qualitative research (Braun & Clarke, 2013).

The current research was conducted by the author, who was a Psychologist in Clinical Training. As much as possible, the author attempted to remain aware of any pre-conceptions about the sample. It was imperative that the findings generated were derived from the responses of participants. In other words, it was important to accurately represent the responses of participants and to ensure that this was not 'filtered' through any particular philosophical or psychological stance that the researcher possessed. In addition it was also important to be aware of any tendency to favour the opinions of those professionals with whom the author previously had a professional relationship with. This was facilitated pragmatically through the use of anonymous identifiers, and through the understanding that any such bias would taint the potential utility of the current research.

It was necessary for me as the researcher to be internally reflexive and forthcoming about the research process (Alvesson & Skoldberg, 2017; Pillow, 2003) as I wanted to ensure accountability for the disciplined use of subjectivity. I kept a reflexive journal

throughout the research process and discussed emerging themes with academic and field supervisors. This helped me to document issues which arose during the research process for later discussion during supervision sessions. This documentation also provided me with an increased awareness of my own degree of implication within the data due to interpretation.

Critical reflections were also noted in the research journal and were considered important throughout of the research process. This research journal recorded reflexive memos, impressions of the data, and thoughts about analysis throughout the process. This process, coupled with my extensive reading of the literature in the area, ensured the flexibility and adaptability in order to generate rich and nuanced findings that embraced and explained the complexity of the real issues under investigation.

Chapter 4: Results

4.1 Introduction

This section presents the findings from a thematic analysis of interviews of 12 participants, comprised of 4 peer support workers (PSWrs), 2 supervisors, and 6 mental health professionals (MHPs).

4.2 Reflections on Research Interviews

4.2.1 Peer Support Workers (PWRs)

The information gathered from the PSWr interviews was very mixed with different PSWrs reporting differences in what their role entailed and whether they felt it fitted well and was integrated into the team. From reflection on the interviews, I questioned whether the PSWrs desire to prove their capabilities in the role limited them fully recounting any difficulties they encountered. Overall the PSWrs emphasised the usefulness of their role which they regard as an effective component of the clinical team and of benefit to the service users (SUs).

4.2.2 Supervisors

The information gathered from the supervisor interviews felt highly relevant with expression of clear opinions and views on the PSWr role. Reflecting on the supervisor interviews as a whole led to a sense of two opposing views. The first of these indicated that although new, the PSWrs had a clear role in the team which would progress and develop further in time with the support of the wider team. In contrast, the second view indicated that the role was under-developed and unclear, and would need much more thought to progress further. It was stressed that teams felt under-prepared and did not fully understand the role. As a result they may not have been able to fully support the development and integration of the role into the team. The overall discussions with the supervisors revealed they perceived the PSWr role as useful to both the team and SUs.

4.2.3 Mental Health Professionals (MHPs)

The felt sense from the MHPs interviews was that they were uncertain about the PSWr role. Upon reflection of the interviews it was clear that MHPs generally had limited contact with PSWrs and had a limited understanding of what the PSWr role entailed. This may have accounted for their overall response. It was clear from these interviews that they saw the PSWr role as under-developed, unclear, and in need of more thought to progress further.

4.2.4 Overall Reflection on Interviews

The information obtained from the interviews was occasionally contradictory, and it became clear that the experiences of different teams varied in respect of the involvement of PSWrs. Despite this, some overlap of the themes generated from interviews across the different participant groups was evident.

4.3 Qualitative Results

Interview transcripts were coded (Appendix F). From analysis of the codes, candidate themes emerged (Appendix I). These candidate themes were refined, with some collapsing onto one another, while other candidate themes were less prominent, had less support by codes, and for this reason are not discussed in this report. A thematic map of final themes from each participant group in each topic was created (Appendix J). These final themes were compared across participant groups and were collated together if there was an overlap (Appendix K). This report is structured in terms of the final themes in each of the nine topics covered in each interview.

4.4 Recovery Themes

4.4.1 Definition of Recovery

When participants were asked to describe the definition of recovery, 3 main themes emerged. As illustrated in Table 10 below, the first theme was evident across all 3 participant groups, while the second and third themes were evident in the supervisor and MHP groups:

Table 10: Definition of recovery themes

Participant groups		
PSWrs	**Supervisors**	**MHPs**
Theme 1: **Personal recovery is unique to each individual**		
Participant groups		
Supervisors	**MHPs**	
Theme 2: **Personal recovery means being able to function in society**		
Theme 3: **Personal recovery is a journey**		

Theme 1: Personal recovery is unique to each individual

It was clear across all three participant groups that personal recovery was perceived as unique to an individual *"I see it as kind of becoming the person you were meant to be" (1:11-12).* A number of MHPs emphasised that the meaning of personal recovery varies from person to person due to *"…the uniqueness of each human being" (9:31).* This is clear from the understanding that *"…everyone has different goals and different things they like to try to achieve." (5:18).* It was further noted that*"…for some people, it may be exactly the same as what the clinician might think, for other people it might be quite different" (6:8-9).* And the focus should concentrate more *"…not our expectations, their [SUs] expectations" (10:11).* One supervisor suggested that some individuals might understand recovery to be *"…returning to a position they were in before. For other people recovering, it might be a new understanding of themselves" (2:4-11).*

Theme 2: Personal recovery means being able to function in society

From the supervisor and MHP participant groups there was a clear sense that personal recovery was aligned with "*functioning the same as everybody else in society" (2:27).* As one MHP explained at length *"Although recovery has to be defined by the individual, recovery is defined in the context of society and one's ability to function in society. It doesn't necessarily mean that everyone is just a sort of autonomous individual who is just doing their own thing. I mean, they're part of communities and they're part of families, they're part of the world, and society, and the human race, and so on. People live in a kind of context, and very often, what people value in recovery is family particularly, or community involvement… That doesn't necessarily mean people are socialising all the time, like, it's just the reality of the world we live in" (6:32-88).* It was

also suggested that skills and tools were needed in order to function in society *"recovery is about building tools and skills" (7:6).*

Theme 3: Personal recovery is a journey

From the perspectives of the supervisor and MHP participant groups recovery was seen as *"an ongoing process…a journey rather than an endpoint" (4:7-11).* As one supervisor observed "*…it takes time to go along that journey and make their own discoveries around it" (2:65-66).* While an MHP commented that although such a journey was hopeful and positive it was not always in a forward direction *"People do take steps back within recovery, and I did say [in] my definition of recovery I think of hope, of positive journey, but there are steps back within that. Sometimes a person's recovery story or their journey isn't always, it doesn't always be, steps forward, but can involve steps back" (3:41-45).*

4.4.2 What is the most important aspect of recovery?

No single common aspect of recovery emerged in response to this question. Rather, different participants chose aspects of recovery they felt were important to them. As a result this theme epitomizes the idea that the most important aspect of recovery is the variation between individuals. This was evident across all participant groups as illustrated below in Table 11:

Table 11: The most important aspect of recovery themes

Participant groups		
PSWrs	**Supervisors**	**MHPs**
Theme 4: **The most important aspect of recovery is unique to each individual**		

Theme 4: The most important aspect of recovery is unique to each individual

A number of participants perceived the concept of hope to be the most important aspect of recovery *"that a person would be hopeful" (3:54),* and also have *"the ability to see hopes" (12:29).* It was suggested that *"without it you lose yourself very quickly into the despair that mental illness brings*" (8:36-39). Other participants felt having a sense of empowerment was the most important aspect of recovery *"I think it has to do with ownership of what is being provided by the mental health services" (9:60-61),* and having *"the autonomy, to be able to make decisions" (8:41).* Another participant

expressed it as being *"…very individual. No person is the same person. If someone is satisfied at a level that they are at, and I suppose we all have expectations of people, if we feel that they could do better. But if they're satisfied at that level, and they don't want to move on, we have to respect that" (10:59-63).* Other concepts that were highlighted included: *"having meaning" (1:42), "learning how to deal with the stigma" (8:48), "just being happy with your life and the way things are going for you…getting back to a place where you're happy and content (5:21-24),"a kind of general ease of being as what I would see as the key thing (6:21-22).* Other participants suggested an important part of recovery included *"being able to have a family life again" (11:33)* while others noted it was through having *"tools and having the skill set to cope" (7:18)* or simply better *"insight and personal awareness" (2:41).*

4.5 Peerness Themes

4.5.1 Definition of 'peerness'

When participants described their definition of peer, 2 main themes emerged; 1 across all 3 participant groups, and the other in the supervisor participant group only as shown in Table 12 below:

Table 12: Definition of peer themes

Participant groups		
PSWrs	**Supervisors**	**MHPs**
***Theme 5:* A peer is someone who has a similar experience to you**		
Participant group		
Supervisor		
***Theme 6:* A peer is someone to aspire to**		

Theme 5: A peer is someone who has a similar experience to you

All 3 participant groups agreed that *"…a peer is somebody who relates to the other person who has that experience, yeah?" (9:110-111).* A number of interviews stressed that such experience did not have to be solely in the area of mental health, as *"it may be that you have two people with very different experiences of mental difficulties, but they may still find a connection. It may be that their connection is nothing even to do with*

their mental health. It could be their age; it could be their gender; it could be an experience that they have had in life" (2:105-110). It became clear from the wide range of definitions of similar experiences were, that there was no 'set' or similar experience required to be a peer. As one participant expressed it *"I think it's a grey area" (1:94-98*).

Theme 6: A peer is someone to aspire to

The supervisor participant group underscored that a peer in a mental health context can be regarded as *"somebody who that you look to and you would aspire to be in so many months' time, or that you feel a genuine, maybe a similar experience, that you've experienced something similar" (2:86-89)* and motivate and inspire as *"…a person who had been or who has been into the same boat, but they're leading a good life, a normal life… Look, I'm here, I was struggling like this, now my mental health is doing fine and I'm leading a normal life'" (12:42-47).*

4.5.2 Limitations of PSWr role

When participants spoke about the limitations of the PSWr role, 3 themes emerged; 1 common theme between the supervisor and MHPs participant groups and 2 further individual themes for the PSWr and MHP participant groups as illustrated below in Table 13:

Table 13: Limitations of PSWr role

Participant groups	
Supervisors	**MHPs**
***Theme 7:* PSWr role is limited as SUs may or may not connect with a PSWr**	
Participant group	
MHPs	
***Theme 8:* Difference in experience of difficulty between PSWr and SU**	
Participant group	
PSWrs	
***Theme 9:* PSWr role is limited by the boundaries of the service**	

Theme 7: PSWr role is limited as SUs may or may not connect with a PSWr

Both the supervisor and MHP participant groups observed *"If you pick randomly from the community, they might have so many preference… I don't see it very different here" (12: 62-65).* Connections are difficult to make a*s "there is such a diversity of service users" (8:169).*Whether a SU connects with a PSWr is highly dependent on*"…who the service user considers their peer or what they see. Commonalities and that, change over time for all of us" (4:35-39).* It was emphasized that this connection may have to be*"…a two-way piece. There has to be a connection on both sides (2:75), "I suppose that you would hope that they would work towards finding a connection" (2:120).*

Theme 8: Difference in experience of difficulty between PSWr and SU

In contrast, MHPs felt a limitation of the peer role lay in the diversity of mental health difficulty experiences. It was purported that *"when you get into the nitty gritty about what my psychosis versus your psychosis, that can be a challenge for people and the peer support worker themselves" (10:140-142).* One MHP further elucidated that "*A 25 year old with an experience of mental health difficulty may be fairly different place to a 70 year old who has their first time experience of a mental health difficulty or dementia or psychosis. So they are two very different things. So I don't know if they are things you would struggle with in terms of peer. So I'd be cautious about using the word 'peer' in terms of everybody can relate to one person's experience" (9:121-133).*

Theme 9: PSWr role is limited by the boundaries of the service

The PSWr participant group admitted they felt limited by the boundaries the service placed on them *"I suppose there is a lot of red tape that goes with being in this--I know that it is necessary and all that. But, I suppose, for me personally, as a new person coming into the service, I find that struggle to try and get to grips in all that" (1:169-173).* As another explained *"We're bound by the policy and now that we've got certain criteria that we have to do and abide by the safety side of it. There are lone working policy and all these different things; there are a lot of policies that we're bound by contract to. That is for safety reasons and kind of a protection, but I think with our role that we're, we test the waters and the flexibility of those policies" (11:87-93).*

4.5.3 Most important equivalent experiences

As with the most important aspect of recovery, when participants were asked to describe the most important equivalent experiences, no single common aspect emerged. Once again different participants chose those experiences they held to be most significant. Consequently, this theme clearly demonstrates that perceptions of the most important equivalent experiences vary considerably between individuals. This was evident across all participant groups as shown in Table 14**:**

Table 14: Most important equivalent experiences

Participant groups		
PSWrs	**MHPs**	**Supervisors**
Theme 10: **The most important equivalent experience is unique to every individual**		

Theme 10: The most important equivalent experience is unique to every individual

It became clear from the interviews that there was no one universal equivalent experience that would support PSWrs and SUs to relate to each other. As one participant expressed it *"I think that the reality is, like, people we work with very often don't fit very neatly into the kind of categories" (6:124-125).* This is evident in the variations in what is considered the most equivalent experience. Some participants felt the most important equivalent experience was being able to relate to someone *"…who's in a similar position in life to us… Isn't it great for us if you hear somebody say, 'God I went through that or I know what that was like and this is what I did'"(2:166-169).* Others felt it was having the experience of any mental health difficulty *"It's the same boat I could say because they have lived experience and they can connect very well with the service user" (12:92-93).* Specific difficulties were noted as being the most important equivalent experiences *"I think hearing voices and obsessional thinking…I think that is something that people would value" (6:110-120).* Still other participants referred to the most common co-morbidities as being the most important experiences *"If I had to think about equivalent experiences and what would be the most important ones, I suppose anxiety and depression come up a lot. There's people with schizophrenia who would have auditory hallucinations of it - visual hallucinations. I think probably more so, the depression and anxiety is probably the most common one, because even people with that experience know anxiety and depression as a result of having schizophrenia, or whatever" (3:147-153).* Others were of the opinion the

precise mental health difficulty experienced was not strictly relevant, since *"…attending a mental health service can be quite a unifying thing because you know nobody can really understand or advocate from that point of view unless you've done that" (7:116-118).*

4.6 The PSWr Role Themes

4.6.1 The role of a PSWr

When participants described the role of the PSWr 4 themes emerged. The first theme was evident across the PSWr and supervisor participant groups. The second theme was evident in the PSWr and MHP participant groups, while the third and fourth theme was only evident in the MHP participant group as illustrated in Table 15:

Table 15: The role of a PSWr

Participant groups	
PSWrs	**Supervisors**
***Theme 11:* The role of the PSWr is to support SU in attaining their recovery goals**	
Participant groups	
PSWr	**MHP**
***Theme 12:* The role of the PSWr is to share lived experience of mental health difficulty**	
Participant group	
MHP	
***Theme 13:* The role of the PSWr is to advocate for a SU and give a lived experience perspective to the team** ***Theme 14:* The role of the PSWr lacks clarity and is a work in progress**	

Theme 11: The role of the PSWr is to support SU in attaining their recovery goals

The PSWr and supervisor participant groups emphasized that assisting SUs in attaining their recovery goals was part of the role of the PSWr. They clarified that they*"…worked with them through an area that they wanted to focus on" (2:184).* Other participants noted that the PSWr suggested that the SUs *"'go and do your homework and find out when it's on and let me know' I can give them a little bit of responsibility, but they don't see that either. And then it's just coming back to the team to say, yes we are doing the day trip, or we are going out wherever, and whenever (11:253-256).* It

was stressed that the PSWr *"is there, on the ground, with them, and accompanying them, taking them out… showing the colours of the world. Very important" (12:156-158).*

Theme 12: The role of the PSWr is to share lived experience of a mental health difficulty

Both the PSWr and the MHP participant groups felt that the role of the PSWr was to share their lived experience of a mental health difficulty with a service user *"they have lived experience that they're willing to identify and share" (3:219-220).* One PSWr observed that more thought is needed about exactly what should be shared with an SU *"I would share different things with different people, depending on the situation" (1:181-182).* One MHP suggested that by sharing their experience they *"help the other person to understand and even to acknowledge that somebody can do well and can live well" (7:145-147).*

Theme 13: The role of the PSWr is to advocate for an SU and give a lived experience perspective to the team

MHPs felt that the PSWr role within the team is *"advocating and coming from a person's perspective" (7:127-133).* This in turn means *"you're getting service user voice and perspective within the team at that level in terms of care planning" (4: 115-116).* One MHP admitted *"…we always think what we do is great and it's fantastic. But when you look at the other side, sometimes it's not so good to the person receiving the service" (10:292-294).*

Theme 14: The role of the PSWr lacks clarity and is a work in progress

The MHP interviews generated a strong sense there was a lack of clarity of what the PSWr role actually entailed, explaining *"It's still a little bit murky" (7:164) a*nd as being *"..less clear than we would have expected for it" (4:88)*. The MHPs were particularly vocal about their struggles to understand the role *"I have observed peer support workers on my team and on other teams, to define the role and to know what it is" (9:199-201).* This perceived lack of clarity around the role left some MHPs feeling uncertain about what the role involved *"It has been a very difficult one for us to tease out…has taken time for us to work out as a team and to work out appropriate referrals. I suppose at the moment, it's, I think, and I may be wrong, this is my impression, it's operating a bit like befriending support services, maybe?" (4:64-71).* It was clear that

MHPs felt they had not developed a proper understanding of what the PSWr did over time, which they rationalized in several ways *"It's still in its infancy at the moment" (7:169),"the establishment of the role is still taking place" (9:118), "I suppose, it's a pilot. It's a new post, so [we] weren't expecting that it wouldn't change over time or anything like that. But it has been very woolly and that has been very challenging because of the lack of clarity around it. That itself has been, is a challenge, and a bit of a disappointment because it's taken, it's still a work in progress" (4:89-95).* It was ultimately suggested that the lack of clarity regarding what the role entailed was *"…understandable because the role hasn't been properly explained" (9:311).*

4.6.2 Similarities between PSWr role and other roles on the team

When participants were asked if there were any similarities between the PSWr role and the other roles on the team 3 themes emerged. The first theme was evident across 2 participant groups. The other themes were evident in the MHP participant group only as illustrated in Table 16:

Table 16: Similarities between PSWr role and other roles on the team

Participant groups	
Supervisor	**MHP**
Theme 15: **PSWrs & MHPs have similar engagement and goals with SUs**	
Participant group	
MHP	
Theme 16: **MHPs like PSWrs may have lived experience of MHD themselves or within their families**	
Theme 17: **PSWrs like MHPs face similar challenges as a new member of a team**	

Theme 15: PSWrs & MHPs have similar engagement and goals to SUs

The supervisor and MHP participant groups agreed that PSWrs have similar engagement style to MHPs. As they variously elaborated *"I'm meeting them at their level…I can see overlap there-just in terms of their approach"(3:236-239),"similar kind of engagement" (10:215),"We both have to build up a rapport with somebody. We both have to listen and ask for their mental health history and even things like we may ask about their daily activities and their routines" (7:212-214), "I would imagine most professionals… how they engage with the person is about personal recovery. I would*

imagine all of our goals are the same. We want people to be personally recovered" (2:295-404). "That intervention piece seems to be – similar" (3:256).

Theme 16: MHPs like PSWrs may have lived experience of MHD themselves or within their families

The MHP participant group pointed out *"If we speak to this model, 1 in 4 will have a mental health difficulty" (9:171).* An MHP can also have a lived experience of a mental health difficulty (MHD) which is similar to PSWrs, although *"There's some assumption that nobody else on the team would have ever had any lived experience on mental health, which I think is a radical assumption, because that's basically impossible given the extent of mental health experiences with people…either [in] themselves or within their families" (4:121-133).* One MHP did note however, that despite lived experience not being *"100% unique to the peer support worker… it's unique in the way they use it" (3:225-229).*

Theme 17: PSWrs, like MHPs, face similar challenges as a new member of a team

The MHP participant group noted that PSWrs face similar challenges to them in terms of being a new member of a team which *"…are not a million miles away from what you face as a clinical psychologist, say, starting out, or as a nurse starting out" (6:150-151).* It was asserted that when a new person joins the team *"you have to find your feet and learn even what skills and what the person can bring to the team" (7:153-156).* Other challenges faced "*for any professional when they meet a team is getting the balance right, do you challenge the status quo, and how much do you go along with the status quo? Now I haven't had these discussions with peer support workers, but I am only imagining that in their heads they are struggling with all of this" (9:241-356).*

4.6.3 Differences between PSWr role and other roles on the team

When participants were asked if there were any differences between the PSWr role and the other roles on the team 4 themes emerged. Themes were evident in separate participant groups only with no cross over as illustrated in Table 17:

Table 17: Differences between PSWr role and other roles on the team

Participant group
PSWr
Theme 18: **Sharing lived experience of mental health gives you a different more mutual connection with SUs.**
Participant group
Supervisor
Theme 19: **PSWr can accompany SU in their goals**
Participant group
MHP
Theme 20: **Willingness to talk about lived experience of MHD**
Theme 21: **PSWrs are different to MHPs as their understanding is through lived experience not through professional training**

Theme 18: Sharing lived experience of mental health gives you a different, more mutual connection with SUs.

All PSWrs interviewed, expressed the view that the sharing of their lived experience made them unique and different from other team member and felt this gave them a more mutual connection with SUs *"I have an 'in' that a lot of people don't have. That's really important because you kind of, you go on in a level playing field, really. That's what the lived experience gives you. It gives that level playing field with that person. I think other people probably didn't have that. That's a huge advantage because then you could start building on the relationship quicker because you got a level playing field to start with" (1:405-411).* Another PSWr echoed these views and explained: *"Well, the unique aspect of peer support role is definitely the lived experience and having that connection that other health professionals can't. We, as peers, are open about our mental problems, and I think that provides the service user that we work with a sense of hope. There's that hope element but it's also being mutual. It's being on the same level playing field as that person, and they really acknowledge and are delighted that that kind of mutuality is there" (8:213-222).*

Theme 19: PSWr can accompany SU in their goals

Supervisors noted that PSWrs were different from other team members as MHPs*"…make tasks with people and they [SUs] go off and do them themselves. Peer is more about being with the person, doing pieces with them to the point then that you're*

going to build their confidence and they're going to do more of those things on their own themselves" (2:272-275). As another supervisor put it, PSWrs are *"not just working; they are walking with them" (12:1225).*

Theme 20: Willingness to talk about lived experience of MHD

The MHP participant group agreed that *"One of the big differences is that we not only have the -, they got lived experience, but they have lived experience that they're willing to identify and share"(3:218-220).* Another MHP elaborated*"…people have lived experience who are also workers in the service. I don't think it's as unique as all that. What is unique is…the peer support worker. It's kind of, they're identifying that openly, they're there because they have lived" (6:335-341).*

Theme 21: PSWrs are different to MHPs as their understanding is through lived experience not through professional training

A number of MHP interviews commented that a PSWrs *"qualification as such, is lived experience. That makes the role different" (4:114).* It was also remarked that *"we all have professional backgrounds. We would have the academic knowledge, we understand symptoms, medication and outcome, that type of thing, but we lack the lived experience aspect" (10:283-289).* And highlighted that *the peer support worker post is different from other professionals because it straddles.., non-professional and professional" (4:109-110).*

4.7 PSWr on a Team

4.7.1 Where does the role fit on the team?

When participants were asked where the PSWr role fits on the team, 4 themes emerged. One theme was evident in both the PSWr and MHP participant groups. Other themes were evident in the MHP participant groups only as illustrated in Table 18:

Table 18: Where does the role fit on the team?

Participant groups	
PSWr	**MHP**
Theme 22: **Knowing where the role fits takes time and is a work in progress**	
Participant group	
MHP	
Theme 23: **Not sure where the role fits due to lack of understanding of role**	
Theme 24: **Whether role adds another dimension to the team depended on the team**	
Theme 25: **Whether role filled a gap for the team depended on the team**	

Theme 22: Knowing where the role fits takes time and is a work in progress

It was clear from both PSWr MHP interviews that the PSWr role was regarded as *"probably still a work in progress" (4:171)"because it's a new role" (1:437).* It was noted that time was a factor in fitting the PSWr role into the team *"Over time the relationship with everybody on the team improved. That they built rapport with everybody on the team" (3:324-325).* Time allows the role to be *"fully integrated as part of the MDT... fully valued as--, well, it used not to be, but now it is turning more so valued" (8:260-262).*

Theme 23: Not sure where the role fits due to lack of understanding of role

The MHP participant groups emphasized that uncertainty about the role fit was the result of a lack of understanding of what the role actually entailed *"We've spent six months working that out and I don't know that we have fully worked it out. Although, now our peer support worker has a caseload, we must have worked it out at some level. I think in terms of the ethos of our team, it fits. It's absolutely fine. It's comfortable, it's not-- it fits.. I think having, even at this point, to have a definition of what the peer support worker role is, make it easier" (4:148-157).* Another MHP explained that *"for everybody it is a bit blurry. So I do think in time if it was to be rolled out and if it was actually to be a really defined role and everyone had an acceptance that this is part of our team" (7:313-316).*

Theme 24: Whether role adds another dimension to the team depended on the team

Despite such MHP uncertainties about the precise fit of the PSWr role fit, they nonetheless agreed that it *"adds to the service. It gives the service another dimension*

let's say. It's about, I suppose, giving a real patient centered approach to our patients" (7:249-251). It was thought that this was achieved through PSWrs giving *"different ideas as in more community based.. that link person to that community and so the peer support worker might be very practical in their thinking.. "Why don't they do this?" And you might go, "I never thought of that." It could be something very simple but the peer support worker just has that great aspect to bring to us" (10:572-579).* Other MHPs on teams confirmed *"in terms of the ethos of our team, it fits. It's absolutely fine. It's comfortable. It's… something that we would have been doing in an informal way in terms of linking people with other service users who may be able to help them. This is a more formalization of that" (4:150-155).*

Theme 25: Whether role filled a gap for the team depended on the team

Some MHP stated they had *"done a lot of talking around it as a team about where we were having difficulties. The areas that we were having difficulties were with helping to set up relationships, community accessing and motivation of service users" (10:232-235),* while MHPs were aware that they did not have the lived experience to fill the gaps, they explained that *"It wasn't from lack of trying but I think it was because we didn't have that jigsaw piece that was missing. That lived experience" (10:340-342).* In contrast, other MHPs felt the role did not fill these gaps as hoped *"gaps in services around kind of rural remoteness... younger males. I think it wasn't quite near for what we hoped" (6:267- 319).*

4.7.2 What supported integration of PSWr into the team

When participants spoke about what supported PSWrs integration into the team, 3 themes emerged. One theme was evident across all participant groups. Another theme was evident in the MHP and supervisor participant groups, and the final theme was evident in the supervisor participant group only as illustrated in Table 19:

Table 19: Integration of the PSWr into the team

Participant groups		
PSWr	**Supervisors**	**MHP**
Theme 26: **The team supporting PSWr to become a member of the team**		
Participant groups		
MHP	**Supervisor**	
Theme 27: **A supportive supervisor**		
Participant group		
Supervisor		
Theme 28: **Some teams more prepare than others for integration of PSWr role**		

Theme 26: The team supporting PSWr to become a member of the team

Across all participant groups the team was confirmed as integral to supporting PSWr integration. It was reported that *"…everybody has been really helpful and supportive" (1:548-549), "…our team are very progressive and very open" (4:208).* As one participant expressed it *"You cannot expect that all team members are really informed…they accommodated" (12:216-218).*

Theme 27: A supportive supervisor

Both the supervisor and MHP groups agreed that having a supportive supervisor was important to integrating the PSWr into the team *"they have a supervisor that would've been known to the team…to introduce them to the team and go with them to the meetings, and even meet them at break time. That kind of thing" (3:301- 305).* It was also confirmed that having a supportive supervisor *"really helped because they have been in our team for a while. They have that contact with other people in this service. And I think that really, really helped. Because the peer support worker had a person to approach…any difficulty or questions, or anything like that" (10:375-385).* Supervision from a supervisor was considered *"invaluable" (8:280*) as the supervisor would *"check in on me not usually all the time but once a week.. I'm not hounded as to what are you doing and who are you seeing, kind of thing.. I would have a leisure time as well that if the supervisor feels that I'm stressed" (11:377-380).* As one PSWr clarified *"I had difficult times coming up to this period, and without the supervisor I would have walked away from the job" (8:281-283).*

Theme 28: Some teams more prepared than others for integration of the role

Within the supervisor participant group there were different views of how prepared the team was for the role. One supervisor noted *"There were some other workshops happened, some conferences took place. And we have been talking about this on our business meetings several times before the peer support worker came on to the ground.. Information sharing, those kind of things" (12:224-232).* Whereas another supervisor felt team preparation for the integration of PSWrs *"…really varies out.. it varies across the teams…" (2:517-519).*

4.7.3 What impeded integration of PSWr into the team

When participants were asked what impeded PSWrs integration into the team, 2 themes emerged. One theme was evident in the supervisor and MHP participant groups and the other was evident in the PSWr and supervisor participant groups as illustrated in Table 20:

Table 20: Impeded integration of the PSWr into the team

Participant groups	
Supervisors	**MHP**
Theme 29: **Teams not understanding the role**	
Participant groups	
PSWrs	**Supervisor**
Theme 30: **PSWrs not knowing how the service works**	

Theme 29: Teams not understanding the role

It was suggested by both the supervisor and MHP groups that teams not understanding the role hindered the integration of the PSWr role into the team *"I think it was a difficulty. No one really knew what it was going to be" (10:505-506), "…there was some confusion and there was some anxieties" (12:285).* It was explained that when PSWrs were originally introduced to the team, there were issues *"I would call it teething problems, because some team members might expect her to do a role of babysitter" (12:308-309).* It was also suggested that supporting PSWr integration into the team could be better facilitated by *"educating the other team members about the role and seeing a value in the pieces that they're doing" (2:331-334).*

Theme 30: PSWrs not knowing how the service works

It was suggested by both PSWr and supervisor groups that PSWrs lack of knowledge of how the mental health service works impeded their integration into the team. As one PSWr elaborated at length *"It's just a huge difference than anything I've experienced before. Trying to get a grip of how the whole thing works, how the meetings work, what they're about, what their notes are about. It's just it's taken me a long time, to be honest. I'm pretty more relaxed about it now but it took me a long time to get the grips and all that. What everybody does is, well- What's the difference between OT and social worker? It's like psychologist and-- There are so many different people and what they all do and there are so many different persons in them. Who or what nurses are they? What's the difference between home-based and community? Even still, I'm getting my head around it. It takes time. That's been difficult" (1:509-522).* Another participant explained *"We're a complicated agency. There's massive demands on teams. There's a load of different structures in place. Even, for example, the complexity of where...their supervisor, they have a line manager and then they have a consultant on the team. We're expecting people to come into our service, understand that, where, they maybe, haven't had that experience to bring them to this point. That's quite challenging" (2:548-544).*

4.7.4 The team's perception of PSWr role

When participants were asked what the teams perception of the PSWr role was, 2 themes emerged which were evident across all participant groups as illustrated in Table 21:

Table 21: The team's perception of PSWr role

Participant groups		
PSWr	**Supervisor**	**MHP**
Theme 31: **Team felt apprehensive/ had concerns about the new role** ***Theme 32:*** **Over time team perceive PSWr role as valuable**		

Theme 31: Team felt apprehensive / had concerns about the new role

Across all three participant groups it was clear that the team was apprehensive and had concerns about the role, and *"they might have been hesitant at first" (8:131),* "*having*

access to the notes" (3:414), "because people were saying, these are service users and they're now on the other side and they're with the professionals and is there going to be an issue of confidentiality?" (10:509-511). Other participants expressed*"...general anxieties because the peer support worker, they're not trained in most of the mental disorders" (12:326-328).*

Theme 32: Over time team perceive PSWr role as valuable

Across all three groups it was clear initial reservations were overcome in time *"I think they were initially when somebody was going in and they couldn't necessarily see the value and as the relationship develops with the peer, that they see the value of that" (2:529-531).* It was generally agreed that over time the PSWr role had come to be regarded as *"a hugely valuable member of the team" (10:583-588).* As one participant summarized *"It really has surprised me how much the role has changed and how much it's valued within the team now, where I thought at the start it wouldn't be" (8:201-205).*

4.7.5 Challenges of being a PSWr on a team

When participants were asked about the challenges of being a PSWr on a team, 4 themes emerged. One theme was evident across the supervisor and MHP participant groups. Other themes were evident in separate participant groups only as illustrated in Table 22:

Table 22: Challenges of being a PSWr on a team

Participant groups	
Supervisor	**MHP**
***Theme 33:* Having to define a new role on a team**	
Participant group	
PSWr	
***Theme 34:* New role trying to prove value of role**	
Participant group	
Supervisors	
***Theme 35:* Practical challenges for PSWr on a team**	
Participant group	
MHP	
***Theme 36:* Having a MHD on a mental health team**	

Theme 33: Having to define a new role on a team

Both the supervisor and MHP groups observed that having to create a new role on a team was a challenge faced by PSWrs since *"They were trying to create their own role and the team did not understand it as well, and not having.. There wasn't a role to fall into" (2:1070-1076).* As noted by another participant *"The peer support worker is -- not only were they new to the team and new out of college, but they were expected to do service development on top of the role. Which normally service development doesn't come into a new person's role. It normally goes into a more senior" (3:481-485).*

Theme 34: New role trying to prove value of role

Another challenge was an overall sense that PSWrs felt they had to prove their value to the team. As one PSWr explained *"I suppose when we have our weekly team meeting. I might not have anything to discuss and it's almost like, "Why have you not had something to raise?" It might just be that I met one person for coffee or sat down had a chat with someone else, it's nothing that valuable to the team that will make a difference to their view of me but I feel like I have to say something just to keep them happy otherwise they'll think I'm nothing all week. This kind of and it's probably not. It's probably just me. But I suppose I feel like I have to prove myself" (11:466-475*).

Theme 35: Practical challenges for PSWr on a team

Supervisors also perceived some practical challenges for PSWrs, such as *"I know with a very early stage they found the MDTs very challenging" (2:379*),*"…the writing of notes on the client file. Because when they start, they have no idea" (12:347-348).*

Theme 36: Having a MHD on a mental health team

MHPs perceived that having a MHD on a mental health team was challenging for PSWrs, explaining that *"It must be quite a challenge to come into a mental health service and be part of a team, when it's explicitly because you have lived experience of mental health difficulties. That must create some sort of challenges. Something around that there's a power differential there. I'm aware that it must be difficult. I think our team are very open to that, but I couldn't say what the peer support workers experience of that has been like" (4:176-181).*

4.8 PSWrs Working Impact on the Service Users (SUs)

4.8.1 Perceived impact of the PSWr on SUs

When participants spoke about the impact of the PSWr on service users, just 1 theme emerged from the PSWr participant group as illustrated in Table 23:

Table 23: Perceived impact of the PSWr on SUs

Participant group
PSWr
Theme 37: **Positive outcome for SU, seen in goal attainment or change in behaviour**

Theme 37: Positive outcome for SU, seen in goal attainment or change in behaviour

The PSWr group noted their on impact on SUs as *"positive because I've had some outcomes" (1:588)*. They affirmed they had seen positive changes for the SUs they have worked with, as two PSWrs elaborated *"what I found was working on his goals… through my input, he was able to go back and socialize again. But yet he was also able to learn about his mental health condition. And he was able to understand what his triggers were and how he can get out of that hole before it reaches a full blown crisis again" (8:470-487),"I've had some people make changes…Because I feel that I can see people a lot longer and a lot more often than in their houses, I have that in. I feel that has helped a lot with people to-- Just to give an example, a person who would have social anxiety, and hasn't been going out at all for ages and ages and ages. Now a person is going to XXX. I hate using the word outcome and everything, but I feel it has been beneficial to people" (1:590-598*).

4.8.2 Perceived challenges for PSWrs working with SU

When participants spoke about the challenges PSWrs faced when working with a SU, 2 themes emerged which were evident across all participant groups as illustrated in Table 24:

Table 24: Perceived challenges for PSWrs working with SU

Participant groups		
PSWr	**Supervisor**	**MHP**
Theme 38: **SU who is severely unwell or complex**		
Theme 39: **Every SU may not want to engage with PSWr**		

Theme 38: **SU who is severely unwell or complex**

It was noted across all participant groups that severely unwell or complex SUs were a challenge for PSWrs. As participants observed *"I think the biggest challenge would be for them coming across people who are very unwell" (9:581-582), "When the peer support worker would have went out, the man wasn't able to engage. He didn't have the capacity to engage with him around recovery; was more unwell than the team initially thought" (2:761-768).* Complex SUs were also found to be a challenge due to their inconsistency *"when we are out she'd say: 'absolutely loved it now, can I see you again next week? But when she called back at the center she would say the complete opposite. So again I'm saying, "I don't know what more I can do for this person when they're playing games like that" (11:290-293).*

Theme 39: **Every SU may not want to engage with PSWr**

All participant groups stressed that it is the SUs decision whether or not to engage with a PSWr. It was observed that it can happen that *"they actually don't want to engage with a peer at all… the person doesn't want to engage and doesn't see the value, or that they actually feel there isn't a clear connection" (2:222-229).* Or it may simply be that *"the person wasn't really open to meeting a new person on the team.. They would have said, 'Okay, I'll meet the peer support worker', but then when they'd meet our peer support worker and thought another new face, another new person, they changed their mind or something" (3:607-612).* It was underscored that in such circumstances, it is understood that engagement is entirely decision of the SU as *"…they have to decide what their hopes are. If they decide that I'm not part of that, then you can let go of that" (1:642-644).*

4.9 PSWrs Working Impact on the Team

4.9.1 Perceived impact of the PSWr on the team

When participants spoke about the impact of the PSWr on the team, 1 theme emerged as evident across all participant groups as illustrated in Table 25:

Table 25: Perceived impact of the PSWr on the team

Participant groups		
PSWr	**Supervisor**	**MHP**
Theme 40: **Challenged the team to be more reflective in how they speak about a SU**		

Theme 40: Challenged the team to be more reflective in how they speak about a SU

Across all participant groups there was consensus that having a PSWr on the team challenged team members to be more reflective in relation to the SU as is evident from the comments of these 3 participants *"I suppose the peer support workers presence in the team has really challenged… teams but it has made them really think about who we're talking about and how we talk about people.. there's been a challenge to be more aware" (2:871-876), "It might not happen overnight but it might start reflective practice, you know?" (9:502-506),"I did say something to challenge something that somebody had said. It was the way they spoke about people who have mental health difficulties. About a person. I didn't like the way they spoke about the person. I felt it was - I didn't think it was respectful, let's put it that way" (1:671-679).*

4.10 The Impact of the PSWr Role on the PSWr

4.10.1 Perceived positive impact of the PSWr role on the PSWr

When participants spoke about the impact of the PSWr role on the PSWr, 1 theme emerged which was evident in the PSWr participant group only as illustrated in Table 26:

Table 26: Perceived positive impact of the PSWr role on the PSWr

Participant group
PSWr
Theme 41: **Being able to help others had a positive impact on PSWrs sense of self**

Theme 41: **Being able to help others had positive impact on PSWrs sense of self**

PSWrs confirm that being a PSWr had had *"a positive impact on my own recovery, because I really feel like I'm making a difference in people's lives and I get a lot of job satisfaction of what I do" (5:401-403).* Two others participants agreed that the role had *"brought so much meaning in my life" (8:736-737),* expressing *"it's all been worth it. I*

can actually say.. I actually did something with my life this year which would be good for me.. I can say, 'Yes, I did that. Accomplished something with my life now'" (11:410-415).

4.10.2 Perceived negative impact of the PSWr role on the PSWr

When participants spoke about the impact of the PSWr on service users, 1 theme emerged as evident across all participant groups as illustrated in Table 27:

Table 27: Perceived negative impact of the PSWr role on the PSWr

Participant groups		
PSWr	**Supervisor**	**MHP**
Theme 42: **The person is the role which makes the role personal**		

Theme 42: The person is the role which makes the role personal

Several participants expressed the view that the PSWr role is based on personal life experience*"… that it ultimately almost forced it to be very personal to that person" (12:128), "it's their kind of approach makes the job, because it's sort of all about them" (6:371).* It was referred to as being *"about a kind of attribute of their self, more so than it's about any kind of professional thing, or so on. I think that's a tough position to be in" (6:375-377).* It was also noted that while other professionals may use reflective practice objectively *"…instead of applying that model, the peer support worker will take it personally" (12:128-130).* One PSWr agreed with this assessment *"I would take it very personally. I was told not to take it so personally but it's hard. I suppose if I worry about it too much, it has a negative impact. Again, I know there was a couple times where I wasn't sleeping. Again, having to go back and see my own consultant and look at things like that" (11:374-392).*

4.10.3 Perceived supports for the PSWr in the PSWr role

When participants spoke about the impact of the PSWr on service users, 4 themes emerged. Two themes in the PSWr and supervisor group, one theme in the PSWr and MHP group, and one theme in the supervisor group only as illustrated in Table 28:

Table 28: Perceived supports for the PSWr in the PSWr role

Participant groups	
PSWr	**Supervisor**
Theme 43 : **Felt adequacies and inadequacies of support from PSWrs** ***Theme 44 :*** **Flexibility in working hours and training**	
Participant groups	
PSWr	**MHP**
Theme 45 : **Supervisor was a support**	
Participant group	
Supervisor	
Theme 46 : **Felt adequacies and inadequacies of support from supervisors**	

Theme 43: Felt adequacies and inadequacies of support from other PSWrs

PSWrs and supervisors expressed conflicting feelings around whether PSWrs received adequate support from other PSWrs. While one felt somewhat supported by means of *"meeting up with fellow peers.. bouncing off our experiences. There's also a Facebook page we have, and that was very helpful for a lot of us. I found it helpful because, truly, it showed me that okay, I'm not the only one here suffering" (8:805-807).* Others stated that*"...training, that was the only time we've actually seen each other. Our only line of communication is through our Facebook page. Not everyone is on Facebook. There is about eight that are missing out on that" (11:437-441).* There was also some disappointment that getting support from other PSWrs *"...just hasn't happened really at the moment" (1:765-767).* It was further noted that support from other PSWrs was lacking and*"...not as much as we liked. I think we had a responsibility around that because of how we located them. Even stuff that we just didn't think about, at the beginning, like the days they work, say maybe. It might have been helpful if the two people were in work the same days as each other, so that they were available to each other, and that even if we could've maybe identified some joint ventures for them, that they had an actual contact with each other" (2:1018-1024).*

Theme 44: Flexibility in working hours and training

PSWrs and supervisors affirmed that PSWrs were supported in picking their hours and afforded opportunities additional training. As two commentators particularly observed *"I got to pick my hours.. There's been ongoing training that I've done, so some on HSE*

land and then other kind of things like fire training, basic life skills and things like that" (5:451-462), "*There was a flexibility around base hours and supposed the career development piece. They're all developing their own interests.. doing WRAP…working for the Recovery College…developing a Hearing Voices Workshop…developing a peer support group. Absolutely. I think that support is there, where we're allowing them to develop extra expertise, or develop areas that they're already interested in, as opposed to just being defined by the kind of type of referrals that they're getting" (2:1104-1115).*

Theme 45: Supervisor was a support

Both PSWrs and MHPs felt that supervisor support was *"really helpful" (5:446)*. It was noted that supervision gave PSWrs *"…a chance to voice my opinions on things and bring up anything that's been bothering me or anything like that" (5:447-484).* It also provided them with *"structure and a power base to be in, within the team" (9:751-752).* It was noted, for instance, that *"…if I felt under pressure. I would be talking. I would be trying to make it to my supervisor more often if I need to" (1:792-793).*

Theme 46: Felt adequacies and inadequacies of support from supervisors

Conversely, supervisors themselves held contrasting views of the support they were able to give to PSWrs. On one hand, it was felt the support given was adequate *"The PSWr was taking…the post personally…I spoke extensively about that and we have been discussing this on supervision sessions so I'd be very careful about that... the freedom to bring personal difficulties to supervision as well but I clarified that supervision is not a counseling session.. .My role is to see…no personal stress is affecting the job. That's what I need to be mindful of so the peer support worker would be supported… I have a standing item on the agenda about personal care… own care plan, how minding the self" (12:137-227).* This opposed the felt sense that the support given was inadequate *"I think my availability, and the availability of the supervisor, line manager it needed more time. It needed more time for me to be there for them, and to be there for their teams, and to do some work with the teams, and understanding the role well and the appropriateness of referrals" (2:1099-1103).*

4.10.4 Factors to maintain PSWrs own recovery

When participants spoke about the factors that help a PSWr maintain their own recovery, 2 themes emerged as evident in the MHP participant group as illustrated in

Table 29. These two themes highlight the lack of structures in place to help PSWrs maintain their own recovery.

Table 29: Factors to maintain PSWrs own recovery

Participant group
MHP
Theme 47: **Need for support structures like other professions**
Theme 48: **Need for clinical supervision**

Theme 47: Need for support structures like other professions

MHP acknowledged the lack of structure around the PSWr role *"There needs to be structure put on that. We all have line managers, but who is their line manager? There needs to be some structure put on that and that needs to be worked out" (3:1080-1084).* It was suggested that like other professions, in the future Irish PSWrs should organize *"a conference and information sharing and in the future a governance cycle of their own, which would be great" (10:119-121).* This was seen as feasible since *"I suppose, say, in 10 years, one would think there would be kind of peer support workers out there who chat to each other and through -, in that way, the people do find support, I think" (6:658-661).*

Theme 48: Need for clinical supervision

In regard of clinical supervision participants emphasized the risks*"...for people if they're on their own recovery pathway and this is part of their journey and they haven't got appropriate clinical supervision because there's a lot of trauma in this work" (4:482-484).* It was observed that*"...across the different disciplines, we underestimate the emotional labour and the toll. We tend to lack that support, like really.. Maintaining recovery is kind of, in a way, seeing that, what people are doing as peer support work is fundamentally psychotherapy. And in the same way as a therapist should be able to have supervision and show to that that's what they would need that, really" (6:610-633).*

4.11 Training of PSWrs

4.11.1 Perception of PSWr training

When participants spoke about the PSWr training, 3 themes emerged. One theme was evident across all participant groups, another emerged in the PSWr and supervisor participants, and a final theme in the PSWr participant group only as illustrated in Table 30:

Table 30: Perception of PSWr training

Participant groups		
PSWr	**Supervisors**	**MHP**
Theme 49: **Training did not give adequate preparation for role**		
Participant groups		
PSWr	**Supervisor**	
Theme 50: **Training perceived as stressful**		
Participant group		
PSWr		
Theme 51: **Hard to juggle course and placement work**		

Theme 49: Training did not give adequate preparation for role

All participant groups agreed that the training needed to better prepare PSWrs for their role: As one participant explained *"To be honest, it didn't…I don't think it was great. I know I did their best, but, I can't -- I dunno what to say. I thought I would have been done differently. I just know what I have wasn't great-- I don't like to make comparisons either, because I know a new course and they're starting up. They're trying to get it going and all that so it is a pilot program. I'm not going to judge them for that. I was looking the one that the Scottish recovery people had, and to be fair maybe they've been around a lot longer for all I know, but their particular program of training seemed to me to be a more comprehensive" (1:804-815).* A number of participants suggested areas which training could give more focus in order to prepare the PSWrs for their role. As these participants observed *"I think they could have done with learning in college in terms of learning basics" (2:1194-1201), "…the bit about the professional communication, both written and verbal, the professional relationships and all of that*

and then the written note-taking piece. I think training needs to-- Those two pieces need to have a little bit more emphasis" (3:1034-1038).

Theme 50: Training perceived as stressful

Both the PSWr and supervisor group confirmed that PSWrs found training particularly challenging*"[they] found the training very stressful…" (12:241), "I think just too much happened too soon and it put us all under a lot of stress" (2:209-210),"I hate to say it, but the training was kind of a disaster" (8:701), "It felt like an internship in peer support but you were completely left on our own" (8:872-873), "…the delivery of it wasn't like a normal college course where you're learning from PowerPoint slides or videos. This one was you're sitting around in a round-table have a discussion on something you don't know about. It made it very hard to learn. I believe most of my learning happened on the job" (8:750-755).* Such issues were the cause of much distress *"I had come out of the room a couple times crying. I wasn't the only one. There was others. There was no check-in from them at all. They would have seen that we had left upset and they wouldn't ask, 'Do you want to have a chat afterwards?' or 'Is it something ?, or 'What upset you?' or whatever. It was like there was no human approach from them. It was all academic" (11:445-451).*

Theme 51: Hard to juggle course and placement work

PSWrs explained that *"receiving the training was kind of ongoing while we were in the job" (5:479), "It was very hard to juggle the two" (8:748)*. This posed additional challenges *"because we were doing the training and trained in our position…back to meet the team a second week…,then we're back in again the week after, then we're back in again.. We've got deadlines to try and get them [portfolios] in, but we're trying to meet, work around both the academic supervisor and the practice supervisors' holidays" (11:512-528).*

4.12 Going Forward

4.12.1 Advice to future PSWrs

When participants spoke about the advice they would give to individuals considering becoming PSWrs, 2 themes emerged, one theme across the PSWr and supervisor participant groups, and another in the MHP participant group as illustrated in Table 31:

Table 31: Advice to future PSWrs

Participant groups	
PSWr	**Supervisor**
Theme 52: **Be in a stable place in your recovery journey**	
Participant group	
MHP	
Theme 53: **Reflect on why you want to do the role and its potential impact on you**	

Theme 52: Be in a stable place in your recovery journey

Both the PSWr and supervisor groups advised that individuals should ideally *"…be a good way in your recovery journey" (8:908).* They maintained the role was suitable *"…for people who are stable and who are doing okay" (12:260)*. It was noted that this was essential since the role is*"… stressful and it is -, you can have very difficult days. I have come home out of here before crying because it was difficult, but it is hugely beneficial for your own recovery" (8:909-911).* As one participant put it*"… you need to be reservoir of energy to give energy to others. You shouldn't be carrying an empty reservoir" (12:262-263).*

Theme 53: Reflect on why you want to do the role and its potential impact on you

In contrast, MHPs felt individuals should think about why they want the role and what impact the role could have on them as a person and be sure to embark on such a role : -*"do it …for the right reasons. That you're not doing it because sometimes people feel they always have to give back to others and sometimes if you have mental health issues, -or problems or illness, it's actually tough enough keeping going yourself" -" (7:586-589).*

MHPs expressed generally held thatthat it was essential that aspiring PSWrs: -*"they've …thought about it;t, that there is a possibility that this is something that could actually set tthem hem back-" (3-1002-1004).*

MHPs

Moreover, they emphasizsed ed the critical need that it was important toto : -*"reflect on this… There are some people who certainly, a peer support worker is*

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something ideal for-- there are some people who you couldn't quite say that" :" (6:765-770).

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Chapter 5: Discussion

5.1 Introduction

Research concerning the involvement of Peer Support Workers (PSWrs) within mental health services remains in its infancy. The results of this study provide significant insights into many aspects to the role from multiple perspectives, thereby painting a holistic qualitative picture of the PSWr role at an early stage in their employment. In-depth interviews were conducted with PSWrs, supervisors and Mental Health Professionals (MHPs) totaling 12 participants to derive qualitative data which was subsequently analyzed using a thematic analysis approach. While accepting the complexity and diversity of individual experiences, a number of distinct patterns were evident. These results help to generate an enhanced understanding of the involvement of PSWrs on mental health teams from manifold perspectives. Major areas investigated

included exploring concepts of recovery, 'peerness', the role and integration of the PSWr, and the impact of the PSWr role on SUs, the team, and the PSWr themselves and their training.

This study is the first of its kind in an Irish context. It offers a number of unique contributions in addition to confirming much of what has been observed internationally about the introduction of PSWr roles. This chapter will discuss some of the themes identified in the context of previous literature. Particular attention will be paid to notable differences between the PSWr, supervisor, and MHPs participant groups. The strengths and limitations of the current study and a critical reflection of the overall research process will be outlined. The relevance of the current findings and implications for future directions for research, implementation and policy will be discussed. The chapter will conclude with a brief summation of the study overall.

5.2 Summary of findings and comparison to previous literature

5.2.1 Recovery

This study explored the definition of personal recovery and the factors deemed important for personal recovery across the three groups, PSWrs, supervisors, and MHPs. The findings of this study corroborate previous research which found recovery to be a complex, multifaceted and individualized concept. Since many recovery elements are unique to the person involved, exhaustive or conclusive definitions are resistant to generalization (Macpherson et al., 2016; Ramon, Healy, & Renouf, 2007; Shepard et al., 2008; Slade, 2017; Slade et al., 2017).

Current research suggests that the addition of PSWrs to mental health teams can support recovery knowledge (Gaffey, Evans & Walsh, 2016). It was interesting to note that based on the interviews, more themes emerged in relation to personal recovery from the supervisor and MHP participant groups in comparison to the PSWr participant group in this study. A theme emerged across all 3 participant groups in this study finding personal recovery to be unique to each individual. This theme encapsulated a broad variety of facets, but with no one predominant aspect emerging. The elements which did emerge mirrored some of the conceptual framework of CHIME, which outlines five categories of recovery processes, including: connectedness; hope and optimism about

the future; identity; meaning in life; and empowerment (Leamy et al., 2011). Other themes to emerge from the supervisor and MHP groups only were the perception of personal recovery as a journey and as the ability to function in society. This finding reaffirms previous research which has also noted that personal recovery entails a journey of growth, a non-linear process comprised of attainable goals, and personal and social development (Davidson et al., 2005; Jacobson & Greenley, 2001; Mental Health Commission, 2005).

5.2.2 Peerness

This study significantly contributes to the dearth of literature on what constitutes 'peerness' in a mental health setting, along with its limitations and the most important equivalent experiences between PSWr and a SU from the perspectives of PSWrs, supervisors and MHPs.

A common theme which emerged across all participant groups found "peerness" in a mental health setting to be ascribed to individuals who have undergone similar experiences to one another. Participants noted that such 'peerness' was not necessarily in relation to mental health experiences, but could be any similar life experience that would support them in building a connection. This supports research by Faulkner and Kalathil (2012) who asserted that support was most fruitful when both peers have other things in common, such as cultural background, religion, age, gender, and/or personal values.

Literature has suggested PSWrs provide benefits to SUs through lived experience, mutuality, and role modelling (Berry et al., 2011; Cabral et al., 2013; Davidson et al., 2006; Doughty & Tse, 2011; Jacobson et al., 2012; Lien & Meissen, 2012; Mead, 2003; Mead & MacNeil, 2006; O'Hagan et al., 2009; Solomon, 2004; Rebeiro Gruhl et al., 2015). Davidson et al 2011 report that the function of role-modelling by a PSWr is to model self-care of one's own illness and explore ways of using experiential knowledge to negotiate daily life whilst having a mental health difficulty and the challenges that accompany this. Recent research has particularly noted role-modelling to be a key mechanism of change for a SU (Gillard et al. 2015). 'Peerness' could also be linked to Bandura's social learning theory where the role model facilitates the acquisition and modification of skills, beliefs and novel behaviours (Bandura, 1986; Rosenthal & Zimmerman, 1978). This theory noted that individuals manage socialisation through

emulating the behaviour of socially competent models (Bandura, 1978). Modelling is a form of social comparison (Berger, 1977) and is hypothesised to depend in part on perceived similarity between model and observer. It is noted, the more alike observers are to models, the more they are able to gauge behavioural appropriateness and formulate outcome expectations producing comparable results to the model (Schunk, 1987). It would be expected that those who possess similar characteristics to share many experiences and outcomes in common. Festinger (1954) hypothesised that observers are more likely to compare themselves to others who are similar in the ability or characteristic being evaluated, especially when information: 1) is unfamiliar, unclear or unavailable, 2) is not immediately followed by consequences, 3) does not lend itself to self-efficacy judgments or 4) where observers have previously experienced difficulties and possess self-doubts about performing well (Akamatsu & Thelen, 1974; Bandura, 1986).

However, attribute similarity does not automatically enhance modelling (Schunk, 1987). It has been suggested from a practice report that there is an inherent tension in allocating people to peer support based on perceived clinical need, in comparison to the choice and control that people ordinarily exercise in forming relationships in the world outside of mental health services (O'Hagan et al., 2009). This practice report was developed by a team who investigated international research literature, legislation, policy and funding for PSWr initiatives around the world. They also held focus groups and 173 interviews with Consumer/Survivor Initiatives, other mental health service providers, researchers, staff from Local Health Integration Networks, the Ministry of Health and Long Term care, ethno-cultural minority groups, aboriginal Canadians and consumer/survivors not associated with Consumer/Survivor Initiatives. Bandura argued that initial similarity or dissimilarity can facilitate generalised matching behaviour but is dependent on the extent to which cues have been associated in the past with paired consequences or paired opposing outcomes for models and observes (Bandura, 1987). For example, if people who share common characteristics rarely experience concordant outcomes, but emulation of a dissimilar model produces favourable consequences, there would be high imitation of new attributes portrayed by a divergent model. Moreover, modelling outcomes are more likely to be achieved by observers if there is a synthesis of previously acquired behavioural elements into new patterns. Those who lack some of the necessary components will potentially display only partial reproduction of a model's behaviour (Bandura, 1978). It may therefore be

helpful if supervisors support the matching of PSWrs with SUs as well as providing adequate supervision to support PSWrs in the event the sought-after connection does not occur.

Across all participant groups, it was found that the most important equivalent experience were unique to every individual SU. This was compounded by a related theme emerging in the supervisor and MHP groups which emphasized that it was the SUs choice whether or not they felt a connection with a PSWr. This was seen as a limitation of the PSWr role. The MHP group only suggested that the difference in experience of difficulty between a PSWr and a SU was also a limitation of the PSWr role. Interestingly only the PSWr group perceived their role as a PSWr to be limited by the boundaries of the service.

These original findings add to the current literature. Future research could extend this knowledge base further by exploring this particular area from the perspectives of the PSWrs and SUs.

5.2.3 PSWr role

Perception of the role of the PSWr

This research contributes to the literature as to date there are a lack of studies which specifically explore the perspectives of PSWrs their supervisors and other MHPs concerning what is entailed in the PSWr role in an Irish context.

Within the literature, the definition of a PSWr has been only loosely defined (Davidson, 2015; Myrick & Del Vecchio, 2016; Rogers et al., 2016). The results of this study indicate that this is also evident in an Irish context. The MHP participant group indicated that the PSWr role lacked clarity and was a work in progress. This is a significant finding as it has been suggested that when non-peer colleagues misunderstand the PSWr role, PSWrs may be excluded, disrespected, and/or silenced (Mancini, 2018). This may stop PSWrs from engaging in the work which is at the heart of their role which is the reason they are employed. The results of this study align with a qualitative study which used thematic analysis to determine how the PSWr role is

defined by PSWrs, supervisors, and clients. The results confirmed a lack of clarity in role definition also evident across these groups (Cabral et al., 2014).

There is currently no widely accepted typology of PSWr services and work activities (Rogers & Swarbrick, 2016). This is mirrored in the lack of common themes across the 3 participant groups. The themes which emerged in this study were nonetheless commensurate with that of previous comparable research. Both the PSWr and the supervisor groups contended that the role of the PSWr was to support SU in attaining their recovery goals, while the PSWr and the MHP groups maintained that it was to share their lived experience of a mental health difficulty with a SU (McLean et al., 2009). Only the supervisor group regarded the role of the PSWr as that of someone to aspire to as a "role-model", with the aim of restoring hope of SUs through positive self-disclosure (Fuhr et al., 2014; Rebeiro Gruhl et al., 2016). The MHP group only asserted that the role of the PSWr was to advocate and convey the perspective of the SU to the team (Gaffey et al., 2016).

It is clear from the variation in themes between individual participant groups that the operational role of a PSWr is extremely unclear. It seems unlikely and probably undesirable that there is any one-size-fits-all set of values and principles underpinning all peer support. However, without a precise understanding of their duties, there is a chance that the PSWrs may assimilate and lose the essence and authenticity of the role which is the main rationale and value for their employment and worse still may lead to unclear boundaries between the PSWr and SU. There is a need for future research to further explore and define the role of the PSWr through the use of relevant stakeholders in order that understanding of how their work is to be boundaried and incorporated into job descriptions, training, supervision etc. It could be argued that when there is consensus about what constitutes a body of peer practice will PSWrs have confidence to apply that practice in their work knowing that they will be supported and valued by colleagues and managers.

Perceived similarities and differences between PSWrs and other MHPs

There is a conspicuous lack of research which directly compares or evaluates the roles of PSWr with that of other MHPs. This study contributes to knowledge as it explored

the views of 3 participant groups, PSWrs, supervisors, and MHPs on the perceived similarities and differences of PSWrs and MHPs.

In terms of similarities, this study found that both the supervisor and MHP participant groups perceived PSWrs to be similar to MHPs in their engagement and goals with SUs. This is parallel to prior research with case managers which found similar results (Crane et al., 2016). The MHP participant group only observed that like PSWrs, MHPs may also have lived experience of mental health difficulty (MHD). This highlights that MHPs may have a dual identity; having both lived experience and being a professional. This has been noted in previous literature which suggests that the proportion of clinicians with lived experience, working using a dual identity is currently unknown, but has been proposed as a potential resource in the mental health system (Gabriel, 2004; Leamy et al., 2016). The MHPs in the current study agreed that PSWrs face similar challenges to all clinical members on joining as a new team. While previous literature claims that new employees in general may experience feelings of uncertainty (Teboul & Cole, 2003), it is suggested that feelings of uncertainty may be intensified for PSWrs as it is also a new role within an organization which lacks role models and established norms (Grant et al., 2012).

In terms of the differences between PSWrs and MHPs, no themes were found to overlap in any participant group. This underscores a strong disparity in perceptions across groups. In keeping with previous research, a MHP theme purported that PSWrs are distinguished from their MHP colleagues in their willingness to talk explicitly about their lived experience (McLean, Briggs, &Whitehead, 2009). The PSWr group maintained their unique contribution to be using their lived experience to build a more reciprocal connection with SUs. This finding perhaps highlights their lack of awareness or understanding that MHPs too may also have lived experience of a MHD. The literature similarly advocates the benefits to the SU of lived experience, mutuality, and role modelling (Berry et al., 2011; Cabral et al., 2013; Davidson et al., 2006; Doughty & Tse, 2011; Jacobson et al., 2012; Lien & Meissen, 2012; Mead, 2003; Mead & MacNeil, 2006; O'Hagan et al., 2009; Solomon, 2004; Rebeiro Gruhl et al., 2015). While previous research comparing the role of PSWrs to case managers identified the specific tasks related to the PSWr domain of empowering SUs; namely, promoting SUs' educational growth, and supporting personal development (Crane et al., 2016), in this study only the supervisor group perceived the unique contribution of PSWrs to be their

ability to accompany SUs on their goals. The MHPs in this study also felt that PSWrs were different to other MHPs as their understanding of a MHD was attained through lived experience rather than through professional training. This also aligns with prior research findings (Fuhr et al., 2014).

5.2.4 PSWr on a team

Perceived factors that supported and impeded integration?

Within the literature there is much research exploring factors which support and impede integration of PSWrs. However, there is a lack of studies which specifically aim to elucidate and compare these factors from the perspectives of PSWrs, supervisors, and MHPs. In this way, this study contributes to the literature.

From interviews conducted across all participant groups, a theme emerged which indicated the team were generally apprehensive and had a number of initial concerns regarding the new role. Nonetheless, it was also evident across all participant groups, that given time, the PSWr role came to be perceived as valuable. This may be explained by a number of additional themes which emerged. Both supervisors and MHPs concurred that a lack of understanding of the PSWr role impeded PSWr integration into the mental health team. This is a significant finding since as it has been suggested such a lack of understanding can lead PSWrs to feel excluded and unaccepted (Kemp & Henderson 2012; Rebeiro Gruhl et al., 2016). This finding is also of note as it is purported that PSWr job satisfaction may be linked to role clarity and attributed to the supervisory understanding of job role (Cronise et al., 2016; Davis 2013; Kuhn et al. 2015; Mancini, 2018). Both the PSWr and MHP participant groups agreed that a proper understanding of how the role slotted into the team took time and was thus seen as a work in progress. This chimes with previous research which posited integration as a process which evolves over time (Moll et al., 2009).

A theme was evident across all participant groups which suggested that the team itself was responsible for supporting a PSWr to become a member of the team. The supervisor group particularly observed that some teams were better prepared than others for the integration of the PSWr role. This finding coincides with a study which conducted interviews with MHPs and PSWrs and concluded that effective integration required organisational readiness (Mancini, 2018). A systematic review evaluating job

satisfaction outcomes for PSWrs employed in mental health settings found the factors contributing to PSWrs job satisfaction included the work environment and employers, employment factors, and collaborative approaches (Chappell et al., 2016). A theme which emerged across the supervisor and MHP participant groups of this study particularly emphasized that a supportive supervisor was integral to the integration of PSWrs. Both the PSWr and the supervisor participant groups observed that PSWrs lack of familiarity with the service systems and processes were potential barriers to integration into a mental health team. This is an interesting and original finding which adds to the literature.

Perceived challenges for a PSWr on a mental health team

Previous research has explored the factors which challenge PSWrs on a mental health team. However, there is an absence of studies which specifically seek to compare the perceived challenges specifically from the perspectives of PSWrs, supervisors and MHPs.

Supervisors and MHPs noted the inherent challenges of defining a new role on a team in the absence of no previous role models or established norms. This is in keeping with previous research findings (Grant et al., 2012). As observed in earlier studies (Vandewalle et al., 2016), a theme arising within the PSWr group reiterated the PSWrs felt under pressure to prove the value of their role. It was noted by the supervisor group that PSWrs were faced with practical challenges of being part of the team in terms of understanding multi-disciplinary team meetings or clinical notes. These interesting results are in stark contrast to findings from a meta-synthesis of qualitative studies which critically compared the experiences of PSWrs and their non-peer colleagues, which found challenging experiences to include: low pay and hours; and difficulty managing the transition from "patient" (Walker & Bryant, 2013).

It has been suggested PSWrs may face stigma when employed in a professional setting which solely aims to treat mental health difficulties (Grant et al., 2012; Walker & Bryant, 2013). Research has shown that stigma from non-peer colleagues can generate a lack of role acceptance (Gates & Akabas, 2007; Gillard et al., 2013; MacLellan et al., 2015). In contrast, it is interesting to note that no such challenges were reported by any of the participant groups in this study. However, it could be countered that the PSWrs

involved concealed or downplayed instances of such stigmatizations, whether consciously or otherwise. A theme from the MHPs expressed that managing a mental health difficulty while working as part of a clinical mental health team may represent major challenges for PSWrs. This perhaps highlights MHPs awareness of and empathy towards PSWrs in this regard.

5.2.5 Perceptions of the impact of the PSWr role on SUs

This study contributes to the literature as it determines the views of PSWrs, supervisors, and MHPs on the perceived impact of the PSWr role on SUs. It has been suggested there is insufficient evidence to support the proposition that a substantial peer workforce would improve the outcomes of people living with mental illness (O'Connor et al., 2017). Trials to date have yielded inconsistent results (Chinman et al., 2014; Lloyd-Evans et al., 2014; Pitt et al., 2013).

The PSWr participant group was found to be the only group which noted that PSWrs had a positive outcome for SUs in terms of goal attainment and/or change in behaviour. It is somewhat intriguing that this positive outcome was not seen by other participant groups to any degree. It may be that what is perceived as positive change by PSWrs differs from that of supervisors or MHPs. It could also be argued that PSWrs painted the impact of their role in a positive light, perhaps treating the interview as an examination of their role. Moreover, the reported positive changes are largely based on anecdotal evidence which inherently precludes their substantiation via the usual measurements of outcome utilized by the service. Thus it may be that positive outcomes for SUs from the perspective of PSWrs are different to that of those employed in traditional mental health services. This would be a vital area for future research and analysis. Rigorous evaluation of PSWr interventions through the use of fidelity measures may also be important in future research. Furthermore, pre-clinical theoretical research needs to be conducted to develop a coherent theoretical framework which explicates the mechanisms of the role of the PSWr and their link to SU outcomes.

5.2.6 Perceptions of the impact of the PSWr role on the team

This study explored the views of PSWrs, supervisors, and MHPs on the impact of the involvement of PSWr on the team. This study contributes to the literature as it has been

noted that there is a dearth of research exploring the impact of the presence of PSWr on a team (Rebeiro Gruhl et al., 2016; Trachtenberg et al., 2013), particularly in relation to their existing culture, values, and practice (Silver & Nemec, 2016) across a range of relevant stakeholders (Gillard et al., 2013) in an Irish context.

Previous research has argued that within a mental health organisations, staff have entrenched negative attitudes and obsolete practices which have been condemned as stigmatizing (Mancini, 2018; Trachtenberg et al., 2013). Group interviews across all participants indicated that the presence of PSWrs challenged the team to be more reflective of the way they discuss SUs. This could potentially be one of the main positive outcomes of the PSW role in services where the above is true. Given time, it is arguable that this additional reflective process may effect fundamental changes in the established ways staff routinely interact, treat, and respond to SUs. It could be further purported that, over time through the presence of PSWrs and the increase in the teams' reflective capacity, that there would be an enhancement in the teams facility to fully understand the challenges confronted by all SUs (Coatsworth-Puspoky et al. 2006).

This study did not derive sufficient evidence to suggest that PSWrs improved team information sharing with SUs (Coatsworth-Puspoky et al. 2006). Furthermore, and in contrast to previous research, this study found no evidence to indicate that PSWrs flexible working arrangements in teams inadvertently produced the negative impact of perpetuating hierarchies within teams (Gillard et al., 2013). It may be that flexible working arrangements already exist in the teams. Further study on the impact of PSWr involvement on mental health teams is warranted before expansion of the role, given the lack of research in the area. Pre-clinical theoretical research resulting in the development of a coherent theoretical framework elucidating the mechanisms of the role of the PSWr and their link to the impact on mental health teams would also be an important area for future research.

5.2.7 Perceptions of the impact of the PSWr role on the PSWr

This study has a unique contribution to the literature as it sought to evaluate the impact of the PSWr role on the workers personal recovery from the perspectives of PSWrs, their supervisors, and other MHPs. A systematic review of qualitative research of PSWrs reports on the impact of the role on their personal recovery found the role to

have the potential to be both facilitative of and detrimental to personal recovery (Bailie & Tickle, 2015). This concurs with the findings of this study.

The PSWrs interviewed in the current study reported that being in a position to help others had had a positive impact on their sense of self. This finding is in corroboration of prior comparable research. It is arguable this more constructive ideation of the self may enable PSWrs to feel more empowered in their own recovery journey (Salzer & Shear, 2002), develop greater confidence and self-esteem (Bracke et al., 2008; Ratzlaff et al., 2006) and alleviate feelings of self-stigmatization (Bracke et al., 2008). Such an interpretation dovetails with the conceptual framework developed from grounded theory by Richards, Holttum and Springham (2016), part of which, posits that positive identity discourses captured the SU experiences of "personal recovery," "lived experience," "use of self", professional "personhood", and insider "activist," (Richards et al., 2016). It is worth noting that this theme did not arise in the supervisor or MHP participant groups. However, it may be that the nature of positive impact is intangible and not discernible to these particular groups, or it may simply have been too soon for such impact to be observed. Moreover, MHPS and supervisors may not have had knowledge of where the PSWr was starting from in their recovery journey.

The theme attesting that the individual in the PSWr role makes the role personal emerged across the 3 participant groups. This theme purports that PSWrs are more likely to take their work personally, which may ultimately have a negative impact on them. It is reasonable to suggest this could be detrimental in line with constructs relating to recovery such as identity, meaning, and empowerment (Leamy et al., 2011). This data has not been derived from any previous research. Further, high-quality research is warranted to sustain a balanced perspective on the range of effects of employment as a PSWr on personal recovery and the factors likely to optimize its benefits to the PSWrs recovery. Unlike previous research this study did not find evidence to support the hypothesis that psychosocial factors of the work environment invariably impact negatively on the PSWrs personal recovery (Stansfeld & Candy, 2006).

As previously noted research to date offers scant assistance in terms of the ideal strategies and methods necessary to properly supervise the PSWr role (Cabassa et al., 2017). This is an area for future research. Themes emerged from the MHP participant group only, which expressed the need for the kind of specialized support structures

provided to other professions, as well the need for clinical supervision for PSWrs. This is an important finding that needs to be considered in future implementation of PSWrs.

5.2.8 Training of the PSWr

A wide degree of variability has been found in the descriptions of PSWr training across numerous reviews (Cabassa et al., 2017; Chinman et al., 2014; Lloyd-Evans et al., 2014; Pitt et al., 2013). This may be attributed to broad spectrum of PSWr roles. As far as the author is aware, no studies have attempted to determine perceptions of PSWr training from the perspectives of PSWrs, their supervisors, and other MHPs.

All participant groups concurred that training did not provide adequate preparation for the PSWr role. It is noted that the PSWr role can be stressful, particularly if the training, supervision and support received is sub-par (Craig, 2004; Yuen & Fossey, 2003). It was suggested by both the PSWr and supervisor participant groups that training was actually perceived as stressful, and indeed this accords with previous research which found that PSWrs find the assimilation of large volumes of complex lecture material arduous (Meehan et al., 2002). Another theme which emerged from the PSWr group only related to difficulties presented by the requirement to juggle course and placement work concurrently. Certainly this may have exacerbated the stress experienced by PSWrs. Future studies should therefore devise and disseminate a categorical description of PSWr training which can be readily piloted and implemented in the mental health services enabling formal evaluation.

5.2.9 Going forward: Important factors for future PSWrs

No research to date has compared the views of PSWrs, supervisors, or MHPs regarding the many critical factors that should be weighed up by individuals considering a future career as a PSWrs.

Both the PSWr and supervisor participant groups agreed on the pre-requisite that PSWrs have attained a stable point in their personal recovery journey. However, in contrast to this, a theme which emerged from the MHP participant group underscored the importance of aspiring PSWrs to reflect on the reasons they are interested in pursuing this vocational path and the potential impact such a role may have on them. These are

interesting results, and highly subjective. Clearly the nature of individual stability, and arguably the concept of recovery itself, is inherently contested and contingent on personal perspectives. As such, it is extremely difficult to quantify in terms of individualized durations of recovery or improved personal capacities. Further questions arise with regard to whether the PSWr or potential employer should evaluate stability, and which reasons to want to become PSWr will convince employers of a serious commitment to this demanding role. Thus future research should explore not merely why individuals aspire to become PSWrs, but also the attendant issues of PSWr recruitment procedures, selection, and training.

5.3 Strengths and limitations

This study extends the knowledge of the inclusion of PSWrs within a mental health team, and is the first of its kind in Ireland. The findings provide insight into many aspects to the role from multiple perspectives, painting a holistic qualitative picture of the PSWr role at an early stage in their employment. As such, rather than investigating effectiveness, this study steps back in order to explore the complex mechanics of their earliest involvement, to shed light on integration and operational difficulties, and address the improvements necessary to bring about changes to the benefit of the overall mental health clinical service and all individual SUs. In essence, failing to adequately construct the PSWr role within the service means that any evaluation of their effectiveness is inevitably construed as meaningless. In short, they were arguably set up to fail. To counter these negative predicates, this study undertook comprehensive analysis based on the genuine response patterns of multiple groups, and derived findings which are highly relevant to successful future implementation of the PSWr role in a mental health setting.

The limitations of this study must also be considered as they may impact on its generalizability and challenge the robustness of the conclusions drawn from the results. It is acknowledged that the sample size, while appropriate for a qualitative study, is perhaps insufficient for application to other populations. Furthermore, while several methods were used to maintain credibility and trustworthiness, the interpretation of interview transcripts may have been inadvertently influenced by the subjective biases and preconceptions of the researcher. Another limitation of the present study was that all participating PSWrs were new to the role. It is possible that more established PSWrs

have developed strategies to negotiate and/or resolve some of the tensions described. Likewise, various forms of response bias may have influenced participant responses. For instance, a positive bias can result in the experiences of those sampled being portrayed in an overly positive light. Another difficulty is that participants may feel they are being personally judged or professionally evaluated. This may have been particularly true in the case of PSWrs, who may have been reluctant to highlight negative aspects or depict their role or the programme in a less than positive manner. However, whether PSWrs were indeed reluctant to be critical is unclear. Finally, it must be noted that findings indicate only perceptions of participants as assessment measures were not used to assess the impact of PSWrs on SUs, teams, and PSWrs themselves.

5.4 Critical reflection

As the primary researcher in the current study it has been important to remain mindful of and acknowledge my centrality in the current study. While my interests and preconceptions in this area were referenced previously, it is important to explore my personal values and expectations in relation to the topics in this project, as it is possible that these may have influenced the interpretative process and compilation of the overall report.

I became quite curious Peer Support working upon hearing that PSWrs were going to be rolled out in some mental health services in Ireland. Having not known anything about this area, I was excited and had so many questions. AS previously mentioned, if this innovative intervention worked, it could help with the long waiting lists that our services face but also support SUs to feel heard.

I was curious about how people who experienced mental health would conceptualize recovery in comparison to those who were employed in services. I thought that even though recovery has many facets that surely there must be some that are more important than others and I thought that this might be different for people who have experienced mental health difficulties versus those who work in a service.

I worried about the term ‘peer’ in PSWr role. I had in my mind that a peer meant being a friend, like a school friend. I wondered if this term would be misleading for SUs. I also felt the term was misleading feeling that the relationship with peers/friends would

grow organically and would be a relationship that would be equal. I also felt he term 'peer' could be likened to a colleague in work. You are more on an equal playing field rather than client and staff, again I wondered about the term 'peer' being misleading for this reason. I wondered if you could force people to be peers by referring them. I wondered what was the most important characteristic that made people your 'peer'. I wondered if this had been thought about and wondered how services were going to navigate this.

I wondered about what their role would entail. I guessed peer support would be accompanying people to appointments and being like a 'sponsor' in Alcoholics Anonymous, who you could call if you felt you were on the "verge of relapse". I wondered if their integration into the team would be challenging seen as there was someone working on the team who could potentially relapse and would that would be like of PSWrs versus the team.

My initial preconceptions centered on how on some level this was going to be a serious challenge and I worried that if this role was not rolled out in a manner which was thoroughly thought through, that damage could be done to the team, the PSWr and the SU. I wondered how you would train a PSWr to be on a team with professionals whilst keeping the focus on their 'experience', which is what the purpose of their role is to be. I felt this was an enormous task.

With all this in mind, I familiarised myself with the disseminated literature in the field of Peer Support Work. As I read about the area, some of my preconceptions were challenged and as I distilled research topics down to a manageable focused question I had to confront my own apprehension and anxieties around sourcing participants. I definitely think I was lucky in that my recruitment was not as challenging as I had expected and people were will to talk about the role as they had to apply to get the post in the first place. Of course, understandably some people were initially apprehensive and guarded around participating. This continued in the initial stages of interviews, particularly early interviews where I was still becoming confident with the interview schedule and the process overall. In fact, my own nervousness was apparent throughout initial interviews and I leaned heavily on the structure provided by having a semi-structured interview schedule.

From transcription it was clear that later interviews were more conversational in nature exploring a potential line of inquiry that participants raised in comparison to initial interviews which were more stilted. I think a key aspect of that shift was the confidence I gathered from initial interviews and reflecting on these within supervision with my supervisor. In addition, a shift from a stance of apprehension to comfort and intrigue facilitated exploration of topics in greater detail and allowed me to adopt a more subtle guiding approach.

The data analysis phase was extremely challenging for me. I experienced despair and struggled and at times feeling overwhelmed at attempting to accurately portray what was being described by my participants. I felt a sense of duty and responsibility to do justice to their experiences and refine it into a manageable, coherent collective account. During these times I relied on my supervisor to ensure that how I was going about analysis was correct. As I reflected with my supervisor on how challenging I was finding my analysis, I was struck by how my felt sense of challenge was mirrored some of content of participant narratives. I was at times weighed down with ongoing threats in the form of insecurity at what felt like a never ending task, unsure if this method of analysis was going to work with so many areas that needed to be highlighted, especially at times when the information obtained from the interviews was occasionally contradictory.

5.5 Recommendations for Future Research

Research into the involvement of PSWrs in a mental health context is coming to the fore. It is becoming increasingly clear that developing a better understanding of the involvement of the PSWr role in mental health services requires a more comprehensive understanding of experiences of the involvement of these roles, and thus should compare the multiple perspectives of all key stakeholders. While this study makes significant advances in this area future research could redress the aforementioned shortcomings of this study. Experiential knowledge must be central to research about peer support so that the academic and clinical assumptions embedded in conventional ways of doing mental health research do not constrain and reconstruct the evaluation of lived experience. Following this, future studies should be appropriately designed to best evaluate the effectiveness of the PSWr role. Research on the involvement of PSWrs in other service settings, such as in forensic or child and adolescent mental health services,

could also contribute to the literature and knowledge base in the area. A number of related further research areas are suggested as follows:

Recovery:

- As PSWrs are considered "Recovery Champions", further exploration of their impact on recovery knowledge of MHPs is necessary going forward. A pre-post-test analysis, both before and after PSWr employment, may be indicative of change in MHPs knowledge of recovery due to PSWr involvement.

Peerness:

- Future studies are required to further explore the concept "peerness" in the context of a mental health setting from the perspectives of both PSWrs and SUs.
- Future research may also explore SUs experiences of the boundaries of 'peerness' when working with a PSWr.

PSWr role:

- There is still a need to address the ambiguity of the PSWr role that currently challenges efforts to establish peer support as a legitimate role within mental health services. Future research could conduct a 'pre-clinical' theoretical phase in order to develop a coherent theoretical framework of 'what peer workers do'.

Integration of PSWrs:

- Future research should aim to explore the PSWr understanding of how a mental health service works and its impact on their integration into the service.

Impact on SUs:

- Future research is required to explore the difference in expected positive outcomes for SUs between PSWrs and MHPs.
- Future research should aim to develop and test fidelity measures to evaluate PSWr interventions with SUs.
- Future research is required to conduct a coherent theoretical framework, describing how the mechanisms of 'what peer workers do' and how this is linked to SU outcomes.

Impact on team:

- There is an opportunity for future research to determine the impact of the presence of PSWrs on a team.
- Future research is required to conduct a coherent theoretical framework, describing how the mechanisms of 'what peer workers do' and how this impacts a team.

Impact on PSWrs:

- The results of this study have highlighted that the PSWr role itself is a personal role. The ramifications for PSWrs need to be further examined in future studies.
- Exploring the experiential realities of PSWrs managing an ongoing personal mental health difficulty while being part of a mental health team, is an area of potential further study.
- It has been noted that research to date provides few details in terms of strategies and methods used to supervise PSWrs. This is a fertile area for future research.

Training:

- There is a need for the development of comprehensive standardized training for PSWrs to better prepare them for the demands of the role. Research is needed to establish a minimum standard of training for PSWrs. A clear description of the training of PSWrs would ensure it could be readily piloted and implemented in other services to ensure that the role is feasible, acceptable, and can be delivered with sufficient fidelity to enable formal evaluation.

5.6 Specific Recommendations for Future PSWr Implementation & Policy

With regard to future implementation of the PSWr role within mental health services, it is questionable as to whether the role of the PSWr, with only tentative evidence for its effectiveness within the literature, should be widely rolled out in mental health settings. It is clear from the results of this study, that significant consideration and planning needs to be given to the involvement of PSWrs in a mental health setting to ensure their professional development and effective implementation. This is of utmost importance so

as future evaluation of their effectiveness within a mental health setting reflects the actuality of their role rather than reflecting inadequate organization going forward.

As a consequence of the results of this study, it has been possible to identify a number of factors which should contribute to the effective implementation of the PSWr role leading to improvement in services. These factors should also be considered in relation to future policy.

Recovery:

- Training for PSWrs should ensure their level of knowledge of personal recovery is of a high standard if they are to act as the "recovery champions" of the mental health services.

Peerness:

- According to the results of this study the concept of 'peerness' was suggested to have limits noting that connection between a SU and PSWr was not automatic and was dependent on the choice to connect by the SU. There needs to be increased awareness of, and sensitivity to this, within a service setting. It may therefore be helpful if supervisors support the matching of PSWrs with SUs as well as providing adequate supervision to support PSWrs in the event the sought-after connection does not occur.

The role of the PSWr:

- This study revealed the need for PSWrs to understand the specifications of their role. This would support them in effectively executing the role. Like other employees of the mental health service, it is hoped that PSWrs could use their role with flexibility and creativity to meet the needs of SUs. Without a precise understanding of their duties, there is a chance that PSWrs may assimilate and lose the essence and authenticity of the role which is the main rationale and value for their employment. Moreover, a lack of understanding of their role may lead to unclear boundaries between the PSWrs and SUs.
- It would be helpful for the team members to be provided with comprehensive information on what exactly is entailed in the PSWr role. This would enable suitable referrals for PSWrs. This information may also help alleviate team members concerns about the PSWr role.

Integration of the PSWr:

- Operational policies should be reviewed to accommodate the PSWr role.
- Clarity of the PSWr role would support PSWrs understanding of where their role fits within the team.
- Adequate training for PSWrs as to how the mental health service operates, along with a period of time for observation within the service, may further support their integration. Training for the PSWr in terms of practicalities of being on a team such as professional writing and verbal communication skills may also support integration into the team.
- Effective integration requires a high level of organizational readiness and may involve adequate orientation and training of staff on the job description, history, codes of ethics, the potential effectiveness of the PSWr role and the advantages and challenges associated with the role. It may also entail clear policies and procedures, and ongoing technical support. Proper resource allocation, especially of supervisors is essential to maximize the beneficial impact of this role.

Impact on SU:

- This study found PSWrs only observed the benefits of their role for SUs. As previously mentioned these benefits may not have been understood from the perspectives of supervisors and MHPs. Systems to manage information about PSWr activity and outcomes for SUs therefore need to be developed. Furthermore, fidelity measures could be used to evaluate PSWr interventions.
- It was unclear from this study whether SUs understood the role of the PSWr. Information materials, such as leaflets, explaining about the concept of peer support, how it can be of help, how to access the service and its boundaries should be made available to SUs. Guidance for Occupational Health professionals in terms of raising awareness of the PSWr role should also be provided.

Impact on team:

- This research highlighted the benefits of PSWr involvement on teams, noting the potential for increasing reflective capacity in how team members speak about and think about the difficulties of SUs. However, more opportunities should be provided for teams to discuss their concerns and review the impact of PSWr involvement on team and individual working.

Impact on the PSWr:

- The results of the research noted that the role had the potential to positively impact on the PSWrs' sense of self. It was also highlighted however, that the role itself is a personal role, and as a result it is important that PSWrs are provided with adequate supervision in this area, as this may exert a negative influence on PSWrs own personal recovery.
- The research results emphasize that supervisors must be allocated sufficient time to be of adequate support to both the team and PSWrs. This study revealed that supervisors assigned one PSWr felt they were in a position to properly support the team and PSWr, as opposed to those supervising multiple PSWrs who did not. In order to avoid the PSWr role exerting a negative impact on individual PSWrs, clinical supervision is imperative. This form of supervision could target issues of transference, counter-transference, and re-traumatisation, thereby supporting PSWrs in their role and helping them to sustain their own recovery.
- Support structures enjoyed by other professions need to be developed for PSWrs.

Training:

- Results of the research suggest that training did not support PSWrs in feeling prepared for their role. Further development in the training is therefore needed and should provide a clear outline of the role and how to perform it. Such training must include information on referral processes, professional writing, and verbal communication skills. In-house training should be considered, for instance, suicide- prevention training, values and recovery-based training, and the management of aggression. Training needs also to instruct PSWrs with clear understanding of how mental health services work, along with a balanced view of different orientations, and different roles of other professionals. However, it must be cautioned that training should not 'over-professionalise' the peer workforce. The approach to training should not send the message that

knowledge learned takes priority over lived experience, however both should be considered of equal importance, with neither being devalued.

- In this study, the role was noted to be stressful with a specific difficulty attributed to juggling college and placement work as the two were concurrent. While the most useful and beneficial way of conducting the training remains unclear, the results suggest the urgent need to address and re-evaluate this pressing matter.

The implementation factors for peer support working outlined above need to be considered by policy-makers at a local and national level. Highly developed policies that include clear guidelines regarding work roles, expectations, paperwork, confidentiality, professional boundaries and accommodations are required and must be made available to all stakeholders involved. When developing policy for the involvement of PSWrs, to sustain fidelity, voices from multiple perspectives need to be heard to develop tangible and measurable targets within services. Future policy initiatives must make greater efforts to include these individuals throughout all stages of policy development and review.

5.7 Conclusion

To conclude, the primary aim of this study was to explore the involvement of PSWrs on a mental health team from multiple perspectives. A comprehensive review of the literature identified the lack of direct comparison specifically between PSWrs, supervisors, and MHPs in the area. It also highlighted gaps in the research in relation to exploring the concept of recovery and 'peerness'. The results of this study suggest that it will be important to develop a clear set of guidelines for the effective implementation of peer support working within mental health services. The following areas need to be given further consideration:

1. Training for PSWrs.
2. Job description for PSWrs which specifies the tasks and duties of the role.
3. Availability of line managers, supervisors and clinical supervision for PSWrs.
4. Preparation of the mental health team and operational policies for integration of PSWr role.

5. Supports and opportunities for the team to discuss the challenges of PSWr involvement on mental health teams.

If the PSWr role is not adequately considered and supported, there is a risk that the potential impact of this role will be constrained and diluted. Clear and consistent championing of peer support from senior managers and policy-makers at a local and national level combined with practical support is critical to the successful absorption of the role into mental health teams. The long-term objective of how peer support should feature within mental health service delivery in the future is not clearly defined. This study has delineated the need to strengthen high-quality research on PSWr involvement in mental health teams. Continuing research on the development of this innovative role is required for integrating this role in mental health services in Ireland.

A critical review of the results of this study in relation to previous literature, as well as strengths and limitations of the study, has been outlined. Significant implications for future directions for research, implementation and policy have been identified and discussed in relation to the topics explored in this study.

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Appendix A

UNIVERSITY of LIMERICK
OLLSCOIL LUIMNIGH

Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

An exploratory study of the peer support worker role within a multi-disciplinary mental health team: Multiple perspectives in an Irish context

Principal researcher:
Ms. Aisling O' Dwyer O' Brien, D. Clin. Psych. student, University of Limerick.
Research co-ordinator:
Dr. Anne Barrett, Principal Social Worker, St. Canice's Adult Mental Health Services.
Supervisors:
Dr. Barry Coughlan, Assistant Director of the Doctoral Programme in Clinical Psychology, University of Limerick.
Dr. Sharon Houghton, Clinical Coordinator of the Doctoral Programme in Clinical Psychology, University of Limerick.

Expression of interest form

Please **fill in the below details** if you agree to be contacted at a later stage to participate in the research project:

Date: _____

Mobile number: _____

E-mail address: _____

Profession: _____

Team: _____

Print name: _____

Signature: _____

Thank you for taking the time to fill out this expression of interest form
Please return to:
Aisling O' Dwyer O' Brien,
XXXX,
XXX,
XX

Appendix B

An exploratory study of the peer support worker role within a multi-disciplinary mental health team: Multiple perspectives in an Irish context

Principal researcher:
Ms. Aisling O' Dwyer O' Brien, D. Clin. Psych. student, University of Limerick.
Research co-ordinator:
Dr. Anne Barrett, Principal Social Worker, St. Canice's Adult Mental Health Services.
Supervisors:
Dr. Barry Coughlan, Assistant Director of the Doctoral Programme in Clinical Psychology, University of Limerick.
Dr. Sharon Houghton, Clinical Coordinator of the Doctoral Programme in Clinical Psychology, University of Limerick.

Information sheet

Dear Sir/Madam,

My name is Aisling O'Dwyer O'Brien and I am studying for my Doctorate in Clinical Psychology at University of Limerick. You are being invited to participate in a research study which has received ethical approval from the Research Ethics Committee, HSE, South East. Please read the following information. If you decide to participate in the study please sign the consent form.

What is this research about?
The pilot project, upon which this evaluation will focus, began with the employment of Peer Support Workers in February 2017 in six mental health areas, locating Peer Support Worker posts within a range of diverse service and geographical settings.

Peer Support Workers were employed on mental health teams to help support people experiencing mental health difficulties. Peer Support Work is a relatively new approach in Ireland and as a result, an evaluation is required to learn more about this way of supporting people.

Why have I been chosen?
As you have been involved in the Peer Support Worker pilot, we would like to give you the opportunity to take part in this evaluation. We would like to know about your views and experiences.

Do I have to take part?
It is up to you to decide whether or not to take part. If you decide to take part you are free to withdraw at any time until your data is no longer identifiable.

What will happen if I agree to take part?
If you consent to participate you will take part in a face to face interview at the service where you are employed. It will be recorded using an audio recorder and will last approximately one hour.

How will the data be used?
From the information collected via interview, conclusions will be drawn for the future employment of Peer Support Workers within statutory mental health services.

Will my taking part be kept confidential?
This research project will abide by the Data Protection Guidelines on Research in the Health Sector. An audio recorder will be used for interviews. This will be kept in a locked drawer in the Adult Mental Health Service. Interviews will be transcribed verbatim into a password protected file on a password protected computer. Following this the interviews on the recorder will be deleted. The transcribed data will be kept for ten years to allow for publications and then will be destroyed appropriately. All information that you give will be kept strictly confidential and we will not use your name or any other identifying information in our reports. No individual participant will be identified in any publication or presentation. Please note that confidentiality is limited as the researcher is professionally obliged to report any allegations of professional misconduct.

What will happen to the results of the evaluation?
The results from this research study will form the basis for my research project for my Doctorate in Clinical Psychology, which will be examined by internal and external examiners. It may also be presented at national and international conferences and may be submitted for publication in peer-reviewed journals. The full report and research findings as well as copies of any subsequent publications will be available to each service for each participant.

What are the benefits of taking part in this research?
Individuals will not be offered any monetary or other rewards for their participation. Your participation would provide valuable information for the future development of the PSWr role and service. An overview of the results of the thesis will be emailed to those who participated and copies of the final thesis will be made available to each service. Finally a presentation on the findings will be made to management and another to all participants who took part at a feedback meeting.

What are the risks of taking part in this research?

There is minimal risk associated with taking part as inconvenience to participants is limited**.** This study will follow full ethical procedures, and confidentiality. Every effort will be made to make participation as relaxed as possible and precautions will be taken to minimise any potential distress.

The research will take place at the site the participant works. The researcher will be vigilant for signs of distress and sensitive in her approach. Participants will be encouraged to ask any questions of the researcher throughout the research process. The participant will be advised that should they experience distress at any time in relation to the study, to contact the principle researcher (Aisling O' Dwyer O' Brien), the research co-ordinator (Dr. Anne Barret), or the Employee Assistance Programme to avail of support and information on further services available.

Important:
In order to participate in this research study, you must sign a consent form. Please note that research practice guidelines do not allow me to accept any exceptions to the standard procedure such as verbal permission. If you have any questions or queries, please do not hesitate to contact me at xxxxx@gmail.com or at the following number 086 XXX XXXX.

Thank you very much for taking the time to read this letter,

Yours sincerely,

Aisling O' Dwyer O' Brien,
Clinical Psychologist in Training,
Principal Researcher.

Appendix C

UNIVERSITY of LIMERICK
OLLSCOIL LUIMNIGH

Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

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Dr. Sharon Houghton, Clinical Coordinator of the Doctoral Programme in Clinical Psychology, University of Limerick.

Consent form

Please **tick the box/es**:

[ ] I confirm I have received and read the information sheet.

[ ] I confirm that the nature of this evaluation has been explained to me and that I have had the opportunity to ask questions.

[ ] I understand that my participation is voluntary and that I am free to withdraw at any time until my data is no longer identifiable.

[ ] I agree that for an audio recorder can be used for the interview for the purpose of analysis only and in accordance with the Data Protection Act 2003.

[ ] I understand that any information collected during this evaluation will be treated as confidential.

[ ] I agree to participate in an interview for the above study.

Date:_____

Print name:_____

Signature:_____

Thank you for taking the time to read the information sheet and filling in the consent form.

Appendix D

UNIVERSITY of LIMERICK
OLLSCOIL LUIMNIGH

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Health Service Executive

An exploratory study of the peer support worker role within a multi-disciplinary mental health team: Multiple perspectives in an Irish context

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Dr. Barry Coughlan, Assistant Director of the Doctoral Programme in Clinical Psychology, University of Limerick.
Dr. Sharon Houghton, Clinical Coordinator of the Doctoral Programme in Clinical Psychology, University of Limerick.

Interview Schedule

Introduction:

You're very welcome to the interview today. The purpose of the research is to compare the views of Peer Support Workers and Mental Health Professionals on a number of topics.

You can take part in this study if you would like to, but you do not have to. If while you are taking part in the study, you would like to stop, for any reason, at all, you can until your data is

no longer identifiable. In this study your identities will not be recorded, so it is confidential, meaning no one will know your results. I have a recorder here, which will help me later to remember what you have said. Once I have written down everyone's answers, I will be deleting the recording. Until that time the recorder will be kept in a locked drawer at a HSE service. All information that you give will be kept strictly confidential. Your name or any other identifying information will be removed before any results that are published. You are welcome to use a fake name if you wish. Your personal information relating to this interview will be kept securely for a maximum of one year. Following this it will be shredded.

Have you any questions?
If you are happy to continue with the interview, please sign the consent form.

Demographics:

Name: _____

Date of interview: _____

Gender: _____

Age: _____

Service: _____

Post: _____

How long qualified: _____

How long in post: _____

Topic One: 'Recovery'

1. In your own words can you define what recovery is? What does recovery look like to you?
2. What part of recovery is the most important aspect to you?

Topic Two: 'Peerness'

1. In your own words can you define what a peer is/what is 'peerness' is in this context?
2. What do you think are the limitations of being a peer in this context? (Prompt for Age, Gender, Ethnicity, Race, severity of difficulty of Service User)
3. What equivalent experiences are most important?

Topic Three: The PSWr role

1. What is entailed in the Peer Support Worker (PSWr) role? (Prompt for tasks, relationships)
2. How the PSWr role has evolved / deviated from what you expected?
3. What do you think makes the PSWr role different from other professional roles? (is it unique and how?)
4. What do you think makes the PSWr role similar to other professionals' roles? (is it similar and how?)

Topic Four: Perception of PSWr integration into the team

1. How does the PSWr role fit in relation to the team you work in? (Prompt for level of integration of the PSWr within the team)
2. What supported the PSWr/you in integrating into the team? What are the key relationships the PSWr/you have within the team/with other workers that helped the PSWr/you to carry out the role as a member of the team? (with whom and why are they key?)
3. What impeded the PSWr's/your integration into the team?
4. How do you think the team members perceive the PSWr's/your role in the team? (Did this change over time?)
5. Did the PSWr/you experience any negative attitude from team members at any stage? (Did this change over time?)
6. What were the key challenges of the PSWr role on the team?

Topic Five: Perceived impact of PSWr involvement on Service Users

1. How would you describe the kind of relationship the PSWr/you needed to develop with Service Users (SUs) to be of help to them?
2. What were the benefits for the SU as a result of the PSWr role? (Prompt around use of recovery, factors that contributed to success, what goals were focused on).
3. Can you give me an example of a case you felt was particularly successful?
4. Can you give me an example of a case that you felt was less successful? (Prompt, barriers, challenges, reasons for difficulties)

Topic Six: Perceived impact of PSWr involvement on a Team

1. To what extent do you feel the presence of a PSWr in your team challenged the professionals on the team? (Prompt around values, culture or organisational practices)
2. Can you give an example of a positive/beneficial impact that you felt the PSWr role may have had on the team members?
3. Can you give an example of a negative/counterproductive impact that you felt the PSWr role may have had on the team members?

Topic Seven: Perceived impact of the PSWr role on the individual themselves.

1. Have you noticed any impact, positive or negative, on the PSWr's/your own recovery? (Prompt for, in what ways, any particular challenges to recover, or reinforcement of own recovery)
2. Could you start by describing to me what sort of support was available for the PSWr/you in the PSWr role? (Prompt around supervision, peer network, training and utilization).

3. Did you feel the support was adequate? (Prompt around flexible working and career development, any additional support needed)

4. Is there any particular support or conditions you feel are important to maintaining the PSWrs/ your own recovery whilst offering peer support?

Topic Eight: Training

1. How well do you feel the PSWr training prepared the PSWr/you for the PSWr role?
2. What kind of training would have been helpful?

Topic Nine: Moving forwards

1. What advice would you give to individuals who might be considering becoming a PSWr in terms of how it might relate to their own recovery?
2. Do you have any suggestions for how the PSWr role or service could be improved?

Topic Ten: Conclusion

The interview is about to come to an end, is there anything else that you would like to add?

The interview has come to an end.

I would like to thank you very much for taking the time to do this interview with me.

Have a lovely day!

Examples of Prompts used during the interview:

Clarifying

- Say what you mean by [term or phrase]
- When you say, [term or phrase], what are you actually doing?
- It sounds like you are saying, ". . . .". Is that a fair summary?
- So you are saying . . . .? [paraphrase]

To get more detail

- Can you give me an example? / Can you tell me more about that?
- What would that look like?
- How do you do that?
- What were other people doing then?
- How did others [e.g., students] respond to that?
- If I were watching you do this, what would I see?

To get feelings thoughts and rationales

- Why was that important to you? / What was significant about this to you?
- Why does that stand out in your memory?
- Why do you think you noticed that?
- Why does that matter?
- What motivated your response?

- How did you feel about that?

To investigate variations

- Do you always response [or do this] this way?
- What might make you respond [or do this] differently?
- Have you always felt this way? / What motivated this change?
- How has your approach changed over time?

Returning to questioning following digressions

- How does this issue relate to the topic we started with?
- Can you recall the associations that led you from our original topic to this one?
- I'd like to understand more about how this relates to the earlier topic we were talking about.

Acknowledging difficult emotions and returning to the area of questioning

- Can you say something about why this issue generated so much emotion?
- What aspects of this issue do you think

Appendix E

Example of Post Interview Participant Memos

Example: 1

The participant spoke for a long time and engaged well in the interview questions. There were many areas this person was interested in and we discussed areas in-depth and at length. I got the sense that they had clear ideas on what they felt was important and what needed change in relation to the PSWr role. The participant explained that their concept of recovery was becoming someone new or getting back to something old. It was clear recovery was service user led, individual to them. When talking about the concept of 'peerness' it was expressed that it changed over time. The participant described 'peerness' as being mutual with someone, not specifically in relation to mental health difficulties but about anything. I am surprised at this interesting idea. The role of the PSWr seemed to be about supporting SUs with goals and being with the person doing this. It seemed that there was a thought that the PSWr might find this challenging as teams can be clinically focused. The differences between team members and the PSWr were that they didn't really have the same time constraints with a SU. I wonder now how other team members will perceive this. In integrating with the team it was felt that people on the team needed to be interested and the supervisor needed to know the team, but that it was up to the PSWr to socialise with the team and get to know them. A key challenge for PSWrs was thought to be getting used to the structures of the agency and finding out the role of team

members. Other challenges for PSWrs were if a SU was particularly unwell or if they didn't want to engage with a PSWr. I never thought about SUs individual choice to engage with a PSWr. Pressure from college to get referrals appeared to have been a struggle for everyone in general, PSWrs, supervisors and MHPs. A struggle for team members was in the change in boundary of the PSWr, the PSWr having been a SU and now working as a member of the team. This caused concern and raised questions around confidentiality. The participant argued that for PSWrs to maintain their own recovery, they had to become aware of their own triggers and take personal responsibility for looking after themselves, bringing things to supervision if necessary. There seemed to be some support from other peers but it was not set in stone. Although this participant seemed to advocate for the PSWr role, it was clear they felt there were a lot of amendments to be made before it would be a useful role.

Example: 2

This interview was quite short. Overall impression is that this participant really does not have much contact with the PSWr and also feels frustrated by the lack of information on the PSWr. It was felt that recovery was defined by the individual and described as a journey, not an end goal. 'Peerness' seemed to be about someone who is like you and who you consider equivalent in some way but is limited depending on whether a SU wants to connect with a PSWr or not. It was expressed that commonalities change for everyone all the time and so 'peerness' is not a static concept. There was a strong sense that this participant did not know what the PSWr did and as a result did not know what referrals to send to the PSWr. They also did not know where the PSWr fit on the team either. There seemed to be an understanding that it was getting clearer over time but still was not clear. It seemed really important to this participant that the PSWr would tell the team what kind of mental health difficulty they had so as it would be easier to match them with SUs. They appeared to be frustrated by this. However they expressed they wanted to be sensitive with the PSWr and not ask what their mental health difficulty was. It was noted that the difference between the PSWr and other members of the team was that they are both a professional and a non-professional and come with a different perspective because of the lived experience of a mental health difficulty. This participant suggested that PSWrs may be similar to some team members, explaining it would be a radical assumption to think that no one else on the team could have a lived experience of a mental health difficulty. However, it was

proposed that the PSWrs overt sharing of this experience with SUs was a difference. This participant wondered if some form of clinical supervision would be necessary to support PSWrs in their work.

Appendix F

Example of coding

No.	Lines 427- 511	Codes
427	**Interviewer:** On to topic four then, peer support work or being on a	Role fit in- fitting in
428	team. How does your role fit in relation to the team you work in?	is a work in progress
429	**Sean:** I've just gotten a text. Would you mind if I checked, just in	-don't know the
430	case?	answer
431	**Interviewer:** Will I pause?	
432	**Sean:** No, it's okay. I'm not going to tell you what it is.	Role fit in- fitting in
433	**Interviewer:** [laughs] [silence]	is a work in progress
434	**Sean:** In case it was my wife. I don't think so. Sorry, what was the	because it's a new
435	question again?	role
436	**Interviewer:** That's okay. How does the role fit in relation to the	
437	team?	Role fit in- has to be
438	**Sean:** Okay. Well, that's kind of a work in progress and I'm not-- I	sold to the team
439	don't know the answer to that one. It's a work in progress because	
440	it's a new role. Then I suppose there is a bit of selling that has to be	PSW not good at
441	done. To be honest, I'm not good at selling but I'm becoming aware	selling – but aware
442	of it that it's something that I need to be doing. It's something that's	need to be doing that
443	a work in progress.	
444	At the moment, I would work with different people in the team,	Role fit in- fitting in
445	different professionals have referred different people to me. I would	is a work in progress
446	then liaise with that person. Explain to them how they were getting	
447	on and whatever. So there would be that going on with different	Role fit in- people
448	people in the team. You know what I mean? So that's how I relate to	refer SUs to PSW-
449	the team as individual's different. What I realize is I would have	relate to the team
450	done that the most, take things individually. There's also work in all	Liaise with team
451	the teams, the doctor and-- Who else have you got? Different	members- relate to
452	nurses, yes. Some of the XXX nurses. It would have been all one	the team
453	mostly and I would have done a bit of work in the beginning,	Explain to team

454	selling, as I say.	members what is
455	**Interviewer:** What would you have been selling?	being done with-
456	**Sean:** Well, I suppose one of the things that we wanted to do as	relate to the team
457	Peer support workers in the region we wanted to get a leaflet	
458	together but because we're all working in different days and we're	Role fit in- Selling –
459	all working all over the place. It's been very hard to coordinate that,	what PSWs do
460	so we haven't been adding them together. Probably, if you get	
461	leaflet together. So, from that point of view, I would just talk about	Peer support workers
462	the few people I'm working with. Just give people a sense of, a	wanted to come
463	flavour of what I'm doing, really. Just to get people, give them an	together and give a
464	idea. It's hard for them to know what they-- People are now	flavour of what
465	referring to me and--[crosstalk]	PSWs do
466	**Interviewer:** What you might tell them? Is it--	
467	**Sean:** I suppose I would tell them the approach I have. Kind of	Role fit in- probably
468	what I've been telling you there really. It's probably not that similar	not that different
469	to other people but it is what it is.	from other roles on
470	**Interviewer:** What do you think supported you?	the team
471	**Sean:** It's probably not that different point of view, so I'm sorry.	
472	**Interviewer:** That's okay. [laughs] What do you feel supported you	Supported
473	in your integration into the team? What supported you becoming a	integration- talking to
474	member of the team	supervisors as
475	**Sean:** Yes. Well, I suppose talking to my supervisors has been	brilliant
476	brilliant.	
477	**Interviewer:** Great.	Supported
478	**Sean:** I've had a buddy person at the beginning, which is good at	integration- buddy
479	the beginning but that's phased out now. That would be good at the	system which was
480	beginning for sure. And the supervisor is the key. That's absolutely	phased out
481	key.	Supported
482	**Interviewer:** Will that be a key relationship?	integration-
483	**Sean:** Absolutely, key. Yes.	supervisors
484	**Interviewer:** Okay. Great. The buddy system, would that have been	Key relationship-
485	another key relationship?	Supervisor
486	**Sean:** Well, there was just at the beginning but that was just-- I was	
487	settling in. [crosstalk] I was trying to get to know who the people	Key relationship-
488	were, just introductions to people, how things worked a bit and that	buddy system
489	kind of thing. I wouldn't know the group. I know this group with the	initially – to settle in
490	person that I had. He's the therapist. Excuse me. Therapist. I would	Role fit in- buddy
491	have run all this group but then, at the beginning, that was months	system helped with
492	ago now. What I mean, that's kind of get to know people and just	know who people are,
493	cut to the end. You know what I mean? So it would have been for	how things worked
494	that. But I suppose these supervisors are an on-going thing that's	
495	important. [coughs] There's obviously-- [coughs]. Issues come up	Role- running groups
496	all the time with different clients or different people, I should say.	– getting to know
497	Supervisors work for that because every time I meet the person, the	people.
498	supervisor, I mean, there'll be different issues. So that's how I'm	
499	going, just go around.	Key relationship-
500	**Interviewer:** Great. Was there anything that you felt impeded your	supervisor- ongoing
501	integration into the team or made it difficult to have a way?	supervisor- important
502	**Sean: [pause 00:34:10]** Myself, probably partly because, as I said,	to help with different
503	I'm not good at selling myself. And so that's something, I've had to	issues that come up
504	learn. As I have said, it's a work in progress. I'm working on it but	with clients
505	it's something I will have to learn more about.	
506	Also, I have no experience in being in a team with 20 people. I've	Impeded integration-
507	never worked in a team with 20 people in all different professions.	PSW themselves- not
508	I've never done that, ever. So that's been a huge change in me. I've	selling role
509	never worked in that kind of side.	
510	**Interviewer:** The learning curve.	Impeded integration-
511	**Sean:** Yes, huge. So that's been-- What was your question again?	no experience of
512	[crosstalk]	being on a team of 20
513	**Interviewer:** What impedes integration into the team?	professionals
514	**Sean:** Yes, that's been difficult. With me, it's just a huge difference	different from
515	than anything I've experienced before. Trying to get a grips of how	anything experience

516 517 518 519 520	the whole thing works, how the meetings work, what they're about, what their notes are about. It's just it's taken me a long time, to be honest. I'm pretty more relaxed about it now but it took me a long time to get the grips and all that. **Interviewer:** There was quite a lot to learn.	before- hard to get to grips with how everything works and what everyone does Impeded integration-getting head around what everyone does takes time

Appendix G

Example of Subthemes

No.1 Clustering of codes	No.5 Clustering of codes	No. 8 cluster of codes	No. 11 Cluster of codes	Subthemes
What is a peer / definition Being a peer is a grey area	**Definition** A peer is someone with similar kind of experiences **Childhood** A peer when younger is someone who was around your age someone to trust and confide in	**Definition** Being a peer means helping someone who has gone through something similar, Being a peer means being there for a person Peers are on the same level Being peer is having both gone through a difficult time Peer is there as a companion to help you get through the difficult time and vice versa Being a peer means giving hope and giving aspects of recovery to someone playing field as a SU	**Definition** Peer- someone who can relate to you Peer- someone who has gone through what you have and has empathy toward you Peer- peers know that both of you have gone through the same thing Being a peer is a bit more than the medical side of it Peer- it is a pure and natural bond **Childhood** peer- is someone you've grown up with	**Definition of peer** **1. Being a peer is a grey area** Being a peer is a grey area **2. Being a peer is helping someone who has had a similar experience to you** A peer is someone with similar kind of experiences Being a peer means helping someone who has gone through something similar, Being a peer means being there for a person Peers are on the same Being peer is having both gone through a difficult time Peer is there as a companion to help you get through the difficult time and vice versa Peer- someone who can relate to you Peer- someone who has gone through what you have and has empathy toward you Peer- peers know that both of you have gone through the same thing **3. Being a peer means giving hope to someone who has a similar experience to you** Being a peer means giving hope and giving aspects of

				recovery to someone playing field as a SU **4. Being a peer is more than medical aspects** Being a peer is a bit more than the medical side of it **5. Being a peer is a natural bond** Peer- it is a pure and natural bond

Appendix H

Example of Candidate Themes

The role of the PSWr- Candidate Themes				**Miscellaneous**	
Willing to share and identify with lived experience of mental health difficulty	**PSWr advocates for SU and gives a lived experience perspective to the team**	**Lack of clarity of the role**		**A befriending role**	**Build relationships**
A peer is able to share experiences with an SS that allows them to share and identify with someone (not feel alone) Unique- lived experience and willing to share and identify Peer role- something around sharing stories Peer role- SU being able to identify with somebody else, share experience sharing experiences Role- PSWs talk a little bit about their MHD Role- PSWs do not go too far into their MHD and have conversations about medication Role of PSW- possible to talk to MHD PSWs have more time to spend with the SU to build relationship – share lived experience and provide hope	Peer explains to other team member progress of SU Peer role- advocating Peer role- giving their point of view Peer role- consult with colleagues who can advocate, support, educate and communicate with a SS on a different level to professionals Peer role- give opinion from having experienced the other side- receiving a service- thus service has been able to change to suit SUs Peer role- aim of role is to get SU voice and perspective in the team and involved in care planning	Peer role- training was clear about what the peer role was not, rather than what it is Peer role- has taken time to work out what it is Peer role- taken time to work out appropriate referrals Peer role- not 100% sure – lack of definition Peer role- not sure what PSW does with someone Peer role- it has been made clear what is not an appropriate referral – makes it hard to figure out what is appropriate Peer role- has been very woolly Challenging because of the lack of clarity of the role Peer role- a disappointment lack of clarity – challenge Peer role- difficulty for PSW finding the parameters of the role Peer role- Hard to understand what it is	Peer role- understand where the person is at- and assist from there Peer role- someone who supports another – without an active piece Peer role- offer support to someone with MHD supporting, speaking, Peer role- meeting service users and working on an area that they want to focus on Peer role- work on individual aspects with each person it could be tailored to meet the need of the service and the SUs Peer role- giving them the additional support they need PSW - can bring the SUs along with her PSW knows when to withdraw support PSW asks if it is ok to withdraw support marrying service users with the community PSW role- link to the	Peer role- befriending support service Peer role- a friend Peer role-a befriending kind of piece Peer role- befriending element = key thing Peer role- friendship Role- peer support- befriending	Build back relationships Peer role- putting them together to build their self-esteem and co-support each other Peer role- build relationships Peer role- set up a friendship group

		Peer role- Hard to have a positive view of what it is Peer role- hard to figure out what it was you were supposed to refer Peer role- referrals did not flow – hard to know what to refer Challenges- what the role might be Peer role- PSWs struggle to define the role and know what it is Peer role- struggle to see what they are doing Peer role- struggle to see what would define a PSW from a pragmatic point of view (activation- café) Peer role- other professionals telling them what their role is PSWs and professionals are trying to define the role Peer role- definition of the role still murky Limitations-Hard to define the role of PSW Limitations- it is important that PSW have a clearly defined role so as not to confuse SS A peer is someone lines can get blurred for unwell SS between nurse and PSW SS struggle with the difference between PSW and CMN- blurry PSW have to find and define their role in MDTs	community – move from institutionalisation to the community Peer role- assisting/ advising/ accompanying them to a service Peer role- Support and education Peer role- signpost them to different services and how to access services and use services in the HSE information, education Peer role- getting SUs involved in the community Peer role- engaging a group of SUs with similar difficulties to help with loneliness – doing activities Peer role- make contacts with community and puts SUs with their different interests involved in the groups Peer role- has diversified into the community more than thought possible- great thing Role of PSW- to explain options to empower someone to get the best out of a service PSW role- they have the experience of going through a mental health service and sit opposite a consultant PSW- dealing with loneliness		

		How they will define themselves in teams and services Key learning- teams need to understand the role Going forward- PSWs need clear idea of role – so that it is valued and respected in the system Key learnings- members of team must have clear knowledge of what is expected Key learning- team must be confident in the person Key learnings- PSW know exactly their role Key learning- PSW must be confident in their role- everyone can get on with their role Key learning- PSW role fluffy/blurry PSW role- perplexity of what the role is – Need for more role definition Key learning points- need for good role definition Role fit- having a definition of what the PSW role is would make it easier (on a team) **Going forward for integration** Going forward- need for team to be prepared what referring people for Key learning points- what is a good or bad referral Mistakes- lack of		

		flexibility on what a PSW can do – due to lack of definition Mistakes- lack of clarity on the role Moving forward- PSWs stating what they bring to the table of the MDT			

Appendix I

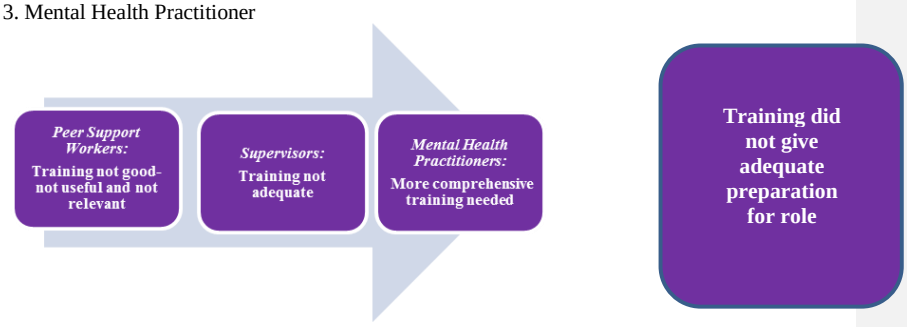
Example of Candidate Themes across Participant Group
Perception of PSWr Training

Appendix J

Example of a Thematic Map of Final Themes across Participant Group for Perception of PSWr training

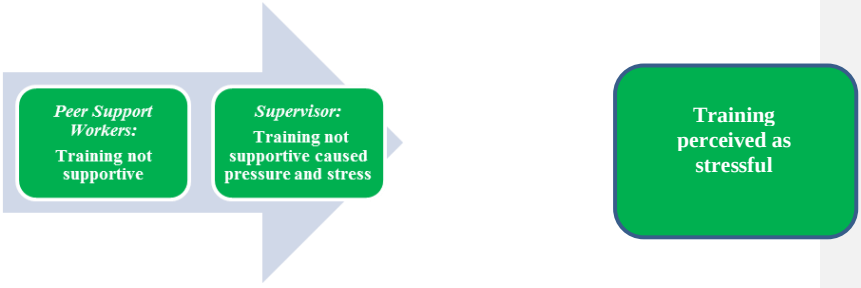
Candidate Themes from:
1. Peer Support Worker
2. Supervisor
3. Mental Health Practitioner

Final theme from 3 participant groups



Candidate Themes from:
1. Peer Support Worker
2. Supervisor

Final theme from 2 participant groups



Candidate Themes from:
1. Peer Support Worker

Final theme from 1 participant group

Appendix K

Example of Final Themes

Perception of PSWr Training

Participant groups		
PSWr	**Supervisors**	**MHP**
Theme: Training did not give adequate preparation for role		

Participant groups	
PSWr	**Supervisor**
Theme: Training perceived as stressful	

Participant group
PSWr
Theme: Hard to juggle course and placement work

Appendix L

Modules in Peer Support Worker Training

Personal Growth and Community Engagement

On completion of this module students will:

1. Have a detailed knowledge and understanding of a variety of underpinning philosophies of psychology, sociology and community development in relation to self and group systems.
2. Have a good understanding and be able to assess different styles of leadership in relation to individual abilities and competencies in judgement and decision making.
3. Be able to analyze interpersonal & leadership skills and processes and propose solutions that are effective in groups and community engagement.
4. Have an appreciation of the necessity and effectiveness of community resources in relation to self and community development.
5. Have a good understanding of the responsibility of the individual and group in supporting/facilitating community learning and development.
6. Critically assess the attributes of and analyse the rationale for citizens to engage in lifelong learning as an empowering choice.

Principles & Practice of Peer Support Working in Mental Health

On completion of this module students will:

1. Have a detailed knowledge and understanding of the historical context of evolving mental health policy and practice in relation to diverse models applied to mental health difficulties and service/professional response.
2. Be able to analyze the concept and possibilities of Recovery in relation to contemporary mental health care.
3. Be able to critically analyse national and international standards for the rights of people with disability and mental health.
4. Be able to critically evaluate national and international practice and policy literature on peer support working.
5. Be able to evaluate the contexts and support needs of people identified as having a mental health problem and the role of peer support workers/advocates.
6. Be able to identify mechanisms whereby personal safety, health and reflective practice are applied.

Mental Health Peer Support Practice Portfolio

On completion of this module students will:

1. Have a detailed knowledge of diverse models of peer support and utilize effective aspects of these models within the context of their service environment.
2. Demonstrate a portfolio of practice skills conducive to the facilitation of support and recovery for people with mental health problems.
3. Have a detailed knowledge of multidisciplinary roles and functions in mental health services provision and potential place of peer support workers in this system.
4. Have a good understanding of HSE infrastructure, policy and professional practice guidelines that apply to all mental health workers in mental health service.